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ISPS-US
P.O. Box 491
Narberth, PA 19072
contact@isps-us.org

THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS
UNITED STATES CHAPTER

President's Column

Brian Koehler PhD
New York University

As I sat down to write this column as president for our ISPS-US Newsletter, the words of Charles Dickens from "A Tale of Two Cities" (1859) came to mind: "It was the best of times, it was the worst of times." In regard to the latter, the daily national, local and international news are heartbreaking. It is so sad to see so many people around the world dying from wars, civil unrest, famine, poverty, poor medical care, etc.In the United States, despite the improving economy, the gap between rich and poor is significantly widening. There are people living in the NYC shelter system who despite working one or two full time jobs cannot afford housing. There is a startling rate of poverty in NYC in our children (around 30%!). Every day on my walk to my office in downtown Manhattan, I see an ever growing number of young people camped out on the city sidewalks holding signs asking for donations for needed expenses. From the early 1970s, I worked in homeless shelters on the lower east and west side of Manhattan, as well as Harlem, as a volunteer and I have witnessed the growth of homelessness and what appears to be serious psychiatric symptoms in many of these individuals. Our health care and social service systems are woefully inadequate. In addition, many of the most well trained and experienced mental health professionals avoid working with persons with significant psychiatric symptoms.

Closer to home, I see the effects of interpersonal conflicts and the avoidance of working things through within our own ISPS-US group, e.g., on our listserv. The latter has been an invaluable resource for many of us since Joel Kantor initiated it many years ago. Lately, dialogue is sometimes broken off (or not initiated) rather than people respectfully and honestly speaking their minds and continuing to make the listserv a safe, informative place for the exchange of views, knowledge, resources, etc. I particularly like the words of Gandhi: "Be the change you want to see in the world." This is a plea for our members for greater responsibility, honesty, empathy, and importantly, humility. I would hope if a member has offended other members on our listserv, she or he would sincerely reflect on the effects of their words, actions, etc., and apologize to those so hurt and offended. I hope that offended members will stay on the listserv in the dialogue, and start other discussions more reflective of their concerns. As Martin Buber said: "All real living, is meeting." How can we help the people who come to us for help, if we cannot resolve, repair, etc., the disjunctions within and between our very selves. As the developmentalists and psychoanalysts have taught us, disruptions and conflicts are inevitable, the important thing is to make honest and sincere attempts to repair these disruptions.

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Editor's note—Dec. 2013

Ross Tappen

This is the first ISPS newsletter since last Winter – your editor apologizes for the delay! Hence we have a double issue containing abstracts from both the recent New Jersey conference and the Chicago conference. Both the Chicago and New Brunswick conferences represented the depth and breadth of our organization. There were in depth panels and papers on theoretical issues from a variety of theoretical frameworks; there were familiar faces from previous conferences; yet there were also a number of presenters that were new to the conference, and brought welcome diversity. The differing emphases of Chicago and New Brunswick were clear in the tone set by the respective honorees and kenote speakers: Danielle Bergeron, Jim Gottstein, Debra Lampshire and Daniel Fisher.

The issue also contains a word from our President, Brian Koehler, as well as news briefs concerning recent decisions by the Executive Committee. There is a literary supplement as well: poems by Derick Adams and Mary Lou Tornes, and an article on a poetry writing and appreciation group by Paul Saks, with poems by the members. I hope you enjoy the issue.

> "Innate among man's most powerful strivings toward his fellow men… is an essentially therapeutic striving."
>
> *Harold F. Searles (1979)*

Newsletter submissions.

Submissions are welcome to the ISPS-US newsletter. The following are some areas of particular interest.

* Book reviews: Please consider doing a review for one of your ISPS colleagues! And, as an incentive, may I humbly suggest that if you want your own book reviewed, please offer to review another's as well, and the universe may be pleased to grant your wish!

*Newer members/early career contributions: If you are a newer member, 3-4 years or less, please consider submitting something. We want to hear from you.

* The public sector: I believe this is a relatively neglected area for us. So many people work in the public sector, or receive services there. Is there something new, different, better or worse at your agency, from your perspective as client or worker.

* Lived experience: What have you learned about your own experiences of madness and your contacts with others in that process.

* Education and training. Did you attend a training or a conference outside of the ISPS-US that particularly impressed you? Let us know. Looking forward to hearing from you!

~Ross
rtappen@mindspring.com

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I would now like to focus on the "best of times." Having been with ISPS in the states before an ISPS-US came into being, and having participated in ISPS events on a regular basis since 1994 (almost 20 years now), and having spent meaningful time with our co-founders, Gaetano Benedetti and Christian Müller, ISPS is very personally important to me, as it is to most, if not all, of our members. It gladdens me to see how much we have matured and grown over the years. I have depended upon members of ISPS for much needed support, guidance, friendship, etc. It truly has been a good home for me and so many others.

The annual ISPS-US conference was held in New Brunswick, NJ. It was ably co-haired by Jessica Arenella and Lori Kalman, with support from Executive Director Karen Stern. The meeting was rich and inspiring, with a special emphasis on service user participation. I was happy to see a great number of our members there to learn, grow and help support this eminently worthwhile conference.

Lastly, as also part of the "best of times," I would especially like to note that the next international conference will be held in New York City March 18-22, 2015, co-sponsored between ISPS-US and the School of Social Work at New York University. The meeting will take place at New York University in the West Village, on beautiful and historic Washington Square Park. Our recent 2013 international conference in Warsaw, Poland, was truly inspiring and successful (over 20 delegates came from the states). Service users were very participative at the conference. I hope to see most of you at ISPSNYC 2015!

In the spirit of ISPS-US NJ 2013 and ISPSNYC 2015, yours,

Brian Koehler
President, ISPS-US

In this Issue

ISPS-US Thirteenth Annual Meeting
Making Contact with the Depths: Psychosis as it is Lived

October 26-28, 2012
At the Chicago School of Professional Psychology
325 North Wells St., Chicago, IL 60654

ABSTRACTS
(In chronological order)

Friday, October 26

Daniel Mackler, LCSW-R, Film and Discussion: *Open Dialogue*

The film *Open Dialogue*, by Daniel Mackler, will be screened, and he will lead a brief discussion of this and similar programs in the world.

Saturday, October 27

Keynote Address: Danielle Bergeron, MD, FRCPC, FAPA

From Psychotic Experience to Civic Responsibility

For the last 30 years, the psychoanalysts and psychiatrists of GIFRIC together with a multidisciplinary treatment team have risen to the challenge of treating psychotics elsewhere than the hospital and otherwise than with medication. Their clinical work consists in guiding patients from psychotic experience to civic responsibility. In order to work in this manner, they refuse the form of discrimination that consists of supposing psychosis to be a deficiency due to a brain disease. For the young adults who ask for treatment, the Center for the Psychoanalytic Treatment of Psychotics in Québec, the 388, offers comprehensive treatment apparatus founded upon a psychoanalytic practice that has been renewed with them specifically in mind. Such an approach opens a space in which it is possible to speak about experiences lived in utmost solitude, beyond the field of language, tormenting the body and dismantling the imaginary. To uphold a place within the social bond for a wish that haunts the patient's unconscious, to give psychotics the freedom to think, to speak, and to act, in active negotiation with others—such is the objective of our work. The entire organization of the Center is conceived in view of this objective. Examining some examples, then, my lecture will discuss the organization of the 388, how it operates, the concepts that underlie psychoanalytic practice with psychotics, and the results obtained through this practice.

Concurrent One-Hour Papers

A. Joanne Greenberg, DHL. *Waiting for Tonto: Making the Best of What We Have*

Two currently prevalent beliefs have been circulating within the mental health community for a while now, which have increasingly concerned me. One belief is a fundamentally messianic one: That if we can only hold out long enough, our health care system will see the light in such a way that we will finally have the resources we need to provide real treatment. The other is fundamentally paranoid: That social orders are purposely, on some broad or organized scale, standing in the way of efforts to provide mental health services where they are needed. Alternatively, I plan to orient my talk along a more positive path, by offering a discussion of the ways in which we might at present make the most of the resources we currently have. I will highlight peer counseling models, the potential for volunteerism that makes a difference in the mental health field, and groups such as the Hearing Voices Network as potential resources that can move our community from a state of helpless waiting to a more active growing force for health.

B. Ronald Abramson, MD. *Mind, Brain, and the Nature of Psychiatry: Principles of Treatment*

Psychiatry is the medical specialty that deals with the diagnosis, treatment, and prevention of mental and emotional disorders: that is, disorders of the mind. On a more conceptual basis, the mind is said to be an emergent property of the brain. But it has also been suggested that consciousness is a fundamental property of the Universe and the brain is like an antenna which receives and focuses this property into a mind. The activities of the brain can be objectively observed using the methods of physical science, but the activities of the mind can only be observed subjectively either through introspection of one's self or through empathic communication with another.

In the early and middle twentieth century, disorders of the subjective mind were the focus of mainstream psychiatry and psychoanalytic thinking was the chief mode of understanding these disorders. However, problems in diagnostic reliability and scientific rigor, advances in pharmacological treatment, and the development of new technological methods of imaging the working brain have led to a shift in emphasis to biological reductionism.

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Now in mainstream psychiatry, mental disorders are defined as "brain diseases," with the subjective mind relegated to "maladaptive thoughts" or to not even exist. Powering this change is not only a mindset toward "hard science" but a result of economic forces which make it more profitable to prescribe drugs than to spend time listening to patients in order to understand the structure and function of their mind.

Although the biological reductionistic focus may seem more scientific, excluding the consciousness, the mind, from consideration is not scientific at all and may, in practice lead to clinical error. Cases will be presented that will document how exclusive reliance on DSM objective criteria led to mismanagement and put patients at risk. Psychiatry must recover the subjective mind.

C. Anne Marie DiGiacomo, MSW, LCSW and Blake Baily, MA, LPC. *Cultivating Openness, Awareness, and Compassion in our Deep Relational Experience Within a Windhorse Therapeutic Environment*

The Windhorse therapeutic approach was developed in 1981 by Chogyam Trungpa and Dr. Edward Podvoll. It is based on the Buddhist understanding of fundamental health, fundamental sanity, and the inseparability of one's entire life from one's environment, while integrating applicable Western psychology. The primary activity involves creating whole person, individually tailored, therapeutic living environments for people with a wide variety of mental health recovery issues.

Within this therapeutic approach, we recognize that one's psychological depths are home to health, intelligence, compassion, fears, loneliness, madness, as well as robust interpersonal activity. We can intuit and experience this interpersonal activity, and through relatively recent brain research, our deep relational interconnectedness is being born out more concretely. As psychotherapists with our clients, we are continually in contact with each other in these depths, whether we are aware of it or not. The contemplative practice of TONGLEN, sometime referred to as SENDING AND TAKING, offers a way for the therapist to bring intention, compassion, and awareness to the process of deep interelatedness. This then cultivates openness and invitation to the relational depths, fostering trust, alliance, mutual recovery, and resilient health for the therapist in the face of his or her own madness and that of the client.

In this presentation we will briefly describe the Windhorse therapeutic approach, then discuss the principles and therapeutic implications of TONGLEN in psychotherapy with people in extreme mental states. We will also introduce the actual practice in an experiential period.

D. James E. Gorney, PhD. *The Psychosis Of Everyday Life: Clinical Implications*

In 1901, Freud charted the many ways in which unconscious conflicts can explode into the fabric of everyday life. In 1947, Sullivan observed that because "we are all much more simply human than otherwise," psychotic experience "is made up of interpersonal processes with which each one of us is or historically has been familiar". This panel will draw upon clinical material to demonstrate how traumatic unconscious conflict activated within psychoanalytic psychotherapy can precipitate the emergence of psychotic phenomena in otherwise non-psychotic individuals.

Following Sullivan, many previous investigators, such as Harold Searles, Otto Will, Françoise Davoine and Jean-Max Gaudillière have deeply illuminated multiple aspects of the psychotic state as an extreme human response to unsymbolized trauma. In the clinical material to be presented here the focus will be upon how such extreme states explode as episodes of madness within the lives and therapies of otherwise non-psychotic subjects. That we all live on the edge of madness is a truism which can emerge with dramatic force within the crucible of transference/counter-transference struggles within the psychoanalytic/psychotherapeutic situation.

Such episodes of unexpected psychotic experience will require the clinician fluidly and flexibly to modify his or her technique. A willingness to engage in symbolic enactment, the creation of transitional space, and other forms of active engagement with the fabric of madness may all become necessary in order to respond to the collapse of normative symbolic, therapeutic exchange. This panel will contend that when psychotic experience erupts into the everyday life of the individual, a fruitful possibility emerges for understanding and resolving a zone of previously unrecognized trauma. Through permitting psychotic phenomena to emerge within the social link of the psychotherapeutic dyad, it may then become possible to integrate this madness into the fabric of everyday life.

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1:00-2:30 p.m. Concurrent Panels

A. Frank L. Summers, PhD, ABPP and Katherine Taylor, MA. *Live Supervision/Case Presentation*

This program will consist of a case presentation of a severely disturbed patient with psychotic anxieties and/or psychotic symptoms. The case will be discussed from the object relations viewpoint. Emphasis will be placed on the application of Winnicottian and neo-Winnicottian ways of thinking about patients suffering from psychotic anxieties. Although theoretical concepts will be utilized, the focus of the program will be on the application of these theoretical ideas to technique. The goal of the discussion will be to provide concrete ideas on how to intervene with such patients. The primary emphasis will be clinical strategy and how to utilize the therapeutic relationship in the treatment of patients suffering from psychotic anxieties and symptoms.

B. Michael O'Loughlin, PhD, Duygu Secil Arac, MA, Jay Crosby, PhD, Almas Merchant, MA, and Katharina Rothe, PhD. *Psychosocial and Phenomenological Inquiry into Chronic Psychiatric Disability: Preliminary Reports*

Participants in this session share common interests in phenomenological and interpretive approaches to understanding the psychoses; they are committed to interpretive qualitative inquiry, and where possible, to collaborative research that involves psychiatric sufferers as co-inquirers. All are part of the same research team. Following three years of collaboration at Austen Riggs Center, Marilyn Charles and Michael O'Loughlin have initiated a project to collect new data at Austen Riggs Center and at Fountain House in New York City. The focus of the research inquiry is on (1) core dynamics; (2) traumatic antecedents and psychosocial stressors; and (3) experience of "being a patient" including phenomenological and cognitive understandings of psychosis, notions of internalized stigma, and facilitative or non-facilitative effects of the care currently experienced in each setting. The conceptual and methodological framework of the research will be explicated and preliminary results will be presented by Michael O'Loughlin, Secil Arac and Ally Merchant. Jay Crosby will present a complementary clinical case study. Katharina Rothe is developing a complementary inquiry into the perspectives of professionals who treat the psychoses and she will present her methodology and some preliminary results from her ongoing work. Time will be reserved for audience questions.

C. Aaron Mishara, PsyD, PhD, Kelsey E. Clews, MA, Megan Kolano, MA and Natasha Reynolds.
Self, Depths and Spirituality: Phenomenology of Psychosis and Healing

1. Spirituality, Psychosis and Healing: A Case report of Living on the Edge. Megan Kolano, MA and Aaron Mishara, PhD., PsyD

For the whole of recorded history, humans have narrated stories of mystical happenings, contact with other worlds, and visionary spiritual experiences of transcendent and maddening proportions (Lukoff, 2011). In many cultures, such contact with the divine signifies the beginnings of a healing spiritual journey; while in others, a "spiritual emergency" is easily reduced to and mistaken for an undesirable psychotic process. Where does transcendent mystical experience overlap with psychosis? And at what point does the difference become clear? Through a clinical presentation of a young woman's journey into and out of a world of angels and demons, we will explore the transpersonal concept of spiritual emergency within the medical culture of our time and wonder how one traverses the precarious landscape of spiritual madness in doing clinical work from a psychodynamic perspective.

2. Distinguishing Spiritual Emergency from Psychosis in Early Schizophrenia: How Phoenix Arises from the Ashes. Kelsey Clews, MA and Aaron L. Mishara, PhD., PsyD

Phenomenological Psychiatrists (Binswanger, Conrad, Jaspers) describe a prodromal period of delusional mood which gives way to delusions of self-reference that eventually resolve the crisis of loss of self in early schizophrenia. In comparison, there is a long tradition of healers who deliberately put themselves into psychiatric crisis, including altered states of consciousness (ASC), which often resembles psychosis, as part of their initiation ritual (Lukoff, 2011; Mishara and Schwartz, 2011). What is the difference between the healer's self-induced spiritual emergency and the onset of psychosis in schizophrenia. We propose that what is present in the spiritual journey of the healer but lacking in the psychosis of schizophrenia is following a period of fragmentation or death of the ego, there is a transformation of self that allows for a greater connection between internal experience and transcendent being beyond the self. The delusions of self-reference in schizophrenia suggest the loss of the ability to transcend one's current perspective (Binswanger, Conrad, Jaspers) by attempting to reestablish the self without spiritual healing, without rebirth of the self from its own ashes. We use the metaphor of death and rebirth of the self (Tibetian Book of the Dead, Jung's depth psychology) to distinguish the qualitative differences of the phenomenology of self in the two states. We also bring similarities and differences in the neurobiology of these different types of ASC.

3. Does Depersonalization have the same phenomenology, unconscious depth processes and neural mechanisms in psychotic and non-psychotic disorders: The case of Delusional Misidentification Syndromes?

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Natasha Reynolds and Aaron Mishara, PhD, PsyD

The construct of human self and how it is affected in different mental and neurologic disorders is complex. One approach to self is to examine the phenomenology of depersonalization in which the experience of self is directly affected. While depersonalization disorder is a unique disorder that stands alone in the DSM IV TR, symptoms of depersonalization are present in the phenomenology of both non-psychotic and psychotic states. Nevertheless, it is not known whether depersonalization is the same phenomenon across disorders. Is it the same phenomenon experienced more intensely on a continuum, or is the experience of depersonalization qualitatively different in psychotic vs. non-psychotic disorders? To what extent do unconscious structures contribute to this phenomenology? The answer to these questions has implications for the treatment as well as understanding the underlying neural mechanisms. As an extreme form of depersonalization, we examine Cotard's and Capgras' syndromes, which are delusional misidentification syndromes (DMS). Notably, a "delusional mood" (Jaspers, Conrad) in which the self is already experienced "as somehow" different or transformed is present in prodromal and in the early course of schizophrenia, just prior to the onset of delusions. Phenomenological descriptions of patients' subjective experience are presented. By employing qualitative-phenomenological research method to these accounts we attempt to determine to what extent the same structure of depersonalization is implicated across the disorders as well as the role that unconscious processes may play a role in the experience of disrupted embodied self in depersonalization.

D. James Ogilvie, PhD and John Shaw, PhD. Discussant: Jean-Max Gaudillière PhD

Contact with "the Problem Itself: "Introducing Bion's Approach to Psychosis

This panel will consist of two presentations, exploring Wilfred Bion's account of psychotic experience. Bion is consistently suspicious of any understanding of psychosis that is not rooted in direct experience. The difficulty describing psychotic experience is of great significance to him. He notes that though he is not confident he can describe the emotional experience of psychosis, he is confident he can evoke it in us. The need to evoke in us what cannot be more directly articulated is linked, for Bion, to his understanding of psychosis as fundamentally involving a crisis in the possibility of experience itself. Through vivid metaphor and startling imagery, Bion brings us to places where the capacity to mind, to think, to feel is in question or under attack. He reveals a dimension of being within which the fundamental capacity for a sense of aliveness is in doubt and, as the panelists will seek to show, in a basic sense under investigation. We are introduced, as Bion puts it in Cogitations, to experiential states where "the problem of emotional experience is itself the problem." Here, "there is...no way of regarding the problem 'as' anything at all." Strikingly, it is by virtue of bringing us into direct contact with such states in ourselves, by questioning our illusions of knowledge in these areas, that Bion's work may open access for us to a different point of view--one described by him as the "psychoanalytic vertex," which in an important sense cannot be known or captured, but can be felt and lived. The panelists will develop several of Bion's key images of psychosis, seeking to foster a reflective atmosphere in which a therapeutic resonance with psychosis might be found. Some clinical implications of Bion's approach will be considered in discussion with the audience.

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Concurrent One-Hour Papers

A. Bertram P. Karon, PhD, ABPP.

Who am I to Treat This Person? What We Feel When Treating Seriously Disturbed Patients

Who am I to treat this person? That's what came to mind every time I treated a seriously disturbed patient. I don't know enough and I have hangups. But no one knows enough, and every therapist has hangups, although our own analysis helps. We may feel confused, frightened, angry, or hopeless because these are the patient's feelings. Discussed are creating rational hope, dealing with feelings (including terror), depression, delusions, hallucinations, and suicidal and homicidal dangers. Theory is helpful, but it is not enough. Tolerating not knowing often leads to effective improvisations. Best results were obtained with psychoanalysis or psychoanalytic therapy without medication. Next best was psychoanalytic therapy with initial medication withdrawn as rapidly as the patient can tolerate. Electroconvulsive therapy is discouraged.

B. Paul Gedo, PhD. *Transference/Countertransference Repetitions of Traumatic Affects*

This paper addresses technical challenges in working with patients who cannot describe their affective experiences in discursive language. I explore certain moments of shared affective experience—first expressed either as enactments, as concordant or complementary countertransference reactions, or as powerful but wordless mutual feeling states—and ways these foster therapeutic growth. These patients require assistance in naming, describing, and thinking about their affective reactions. Their defenses against emotional experience create deficits in cortical control. The difficult dyadic work of naming, containing, considering, and modulating affects gradually ameliorates these deficits.

C. Elizabeth A. Johnson, PhD and Kathy Steinmetz, MS.

Swimming in the Deep End: Using Behavior and Insight to Guide a Life Well-Lived

Schizophrenia occurs four times more often in people with intellectual disability than in the general population. The presentation of schizophrenia in people with intellectual disability is similar, with the exception of increased behavioral changes. Persons with schizophrenia and mild mental retardation have been shown to benefit from psychotherapy and other psychological treatments such as psychosocial and behavioral therapies.

One benefit of studying schizophrenics with intellectual disability is the knowledge about the illness gained by studying behavior that may otherwise be inhibited. Unusual, cause-related behavior is another language that can assist in telling the lived experience of someone with schizophrenia. Behavior is particularly informative if the individual shows openness and insight into his/her behaviors and if his trained caretakers can bring additional observations and theories into the equation.

This presentation features a case study of a man with paranoid schizophrenia and mild mental retardation who has demonstrated extraordinary fortitude in the face of multiple adversities. Diego's psychologist is the leader of his treatment team and works with him in individual psychotherapy. Together they also design behavior treatment plans that are followed by everyone on the treatment team. Diego has the difficult task of managing a relationship with a therapist who invokes behavior plan consequences for him as well as works with him in psychodynamic therapy. Diego's illness is stable but his residual paranoia results in odd and sometimes bizarre behavior in the community. His insight allows for the language of his life to be accessible and unusually informative.

This presentation includes information from the members of Diego's treatment team as well as segments from his therapy sessions. The presenters attempt to integrate the elements of Diego's treatment and to make contact with the depths of his psychosis as it is lived.

D. Susan E. Mull, PhD. *Protest Language of the Abject*

In the experiential territory shared between states of trauma and madness, abjection often holds a central place. In the place of abjection one feels reduced to the position of the sub-human, the cast-away, to the unholy and defiled one. Often, in the presence of the Other, a personal-sense-of-being dissipates and disassembles, and the ability to communicate one's pain in coherent language falls away. The only language accessible is often the pre-language of cries, screams, whimpers, word-fragments, and concretized images.

Within this experiential language lies a discourse of pain, but also a discourse which precedes pain, a root language embedded in the vastness of human communication. The purpose of this paper is to demonstrate how the language of the abject is best understood as not simply a language of unsymbolizable pain, but as a language of protest, calling humanity to struggle against forces of the abject, as they manifest psychologically , socially and culturally. Two cases are presented for discussion. In each, the focus is on the pre-language of the abject and how it functions as both a cry of resistance, and a call for solidarity.

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Concurrent One-Hour Papers

A. Patrick B. Kavanaugh, PhD. *On the Mystery, Magic and Muscle of Communicating with the Madness of Self and Other*

Each of us has a story to tell. And in its telling to another, we reveal something about the history and mystery of who we are, where we come from, and how we have imagined ourselves into being. This paper is about the story of how he came to be as told over a five year period of time by a man on the inpatient unit of an inner-city state hospital. It reflects the palpable and mysterious experiences of psychic transformation as it is lived in the telling of his story to another.

In the context of illustrative material, this paper is organized around a shamanic way of thinking, being and presencing that, in effect, allows–and encourages–the practitioner to make contact and communicate with the madness of the other (of self). Its focus is on the process of listening, understanding and responding to the madness of self and other when premised on the Freudian unconscious. Its emphasis is on a magical (as opposed to a medical-scientific) visionary experience. In so doing, it invites the voice of madness into, at once, the practitioner's psychology, space, and discourse.

Along the way, consideration is given to some of the more prevalent institutionalized fears of madness that are so deeply embedded in the master narrative of the medical-scientific tradition, are embodied in our mainstream psychoanalytic psychologies, and come together to foreclose on making contact -much less, communicating- with the depths of madness.

B. Annie G. Rogers, PhD. *Ghosts from the Ineluctable: Psychosis and the Enigma of Language*

In this presentation I will speak to my own experience of psychosis as a teenager and young adult, and my life beyond that time following psychoanalysis. My experience involved hearing voices, working to transform language, and a conviction that various beings inhabited my body through invasive objects. These ghosted workings of the ineluctable have changed for me over time–and I will attempt to describe how I understand them now. I will use this experience from the depths to consider how language transformations create ghosts that are, in fact, truths from psychosis-drawing on the micro fiction of Robert Walser, the poetry of Tomas Transtömer, and the writings of psychoanalysts Jacques Lacan and Willy Apollon.

C. Ann-Louise S Silver, MD. Chris Burford Memorial Lecture:
Christopher Burford, MD: His Contributions to ISPS

Chris Burford contributed mightily to ISPS, predominantly through his creation of and contributions to the listserve of ISPS. He served on the Executive Committee of ISPS, and regularly flew across the Atlantic to attend our annual ISPS-US meetings, all this while struggling with a chronic and ultimately fatal illness. This talk pays tribute to his contributions, acknowledging the intensity with which he raged against the dying of the light.

D. Daniel Mackler, LCSW-R. *The Underlying Principles of Various Successful Psychosis-Oriented Programs*

I have spent the last two years traveling around Europe and North American visiting about a hundred different psychosis-oriented programs. I have spoken with clinicians, consumers, former consumers, and family members and at each program have been studying what works and what doesn't. What I have observed is that most of what is out there doesn't work particularly well. However, there are a few programs that do work fairly well, and some that work beautifully. I have examined these programs carefully in order to parse out the principles upon which they are based. My talk will explore these principles and the ramifications of each. Interestingly, these principles are not very complicated and in most cases are quite logical -- even to non-professionals, and sometimes especially to non-professionals. This highlights a main problem hindering a wider acceptance and use of these principles: that by and large they go against the mores of the traditional psychiatric and mental health field as well as the training of so many mental health professionals.

Concurrent Half-Hour Papers

A. Bill Gorman, PhD, ABPP. *The Helper's Balance When Encountering Trauma and Suffering*

The helper engaging with an individual in distress may be confronted by two opposing dangers. The first is enmeshment in which one becomes overly absorbed experientially into the person's plight with the consequences of transgressing essential boundaries or developing secondary trauma. The second is detachment in which one becomes defensively removed from any real appreciation of the plight with the potential for connective failure or burnout. The solution for avoiding both outcomes is to work figuratively with "one foot in and one foot out," a dualistic stance often easier cited than effected. It is also a balance constantly shifting, within and between meeting intervals, and even more so from one individual to another and one cultural framework to another.

This complementarity can require acute self-awareness, self-care, and flexible equilibrium on the part of the helper. In

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one classic therapeutic system, it was referred to by Harry Stack Sullivan as the dynamic process of participant/observer. It encompasses the dialectic simultaneously of seeking subjectively to understand phenomenologically, or from "within," the other's reality while also maintaining objectively a more critical monitoring of theory, context, and one's own reactions, including counter-transference. The former aspect is a function of one's empathic and relational capacities, and the latter draws upon one's psychological knowledge, self-reflection, and use of training, consultation and supervision.

Both sides present challenges of continued development for the helper, demanding honest humility in acknowledging that in every endeavor to engage there can be more to learn, about both oneself and the other. And it is all the greater when the other is in some respects in extremis, for example, by reason of a psychotic condition, a severe trauma, or a significant cultural difference. However, this presentation will argue that the common existential grounding and a disciplined compassion for the other can bridge many such chasms with benign effect.

B. Mihaela E. Bernard, MA, LPC. *A Case of Childhood Psychosis: The Emergence of the Subject*

The paper presents the ongoing treatment of a case of childhood psychosis with respect to the question of the emergence of the subject via imaginary play with a counselor in a residential milieu treatment setting. The paper outlines an attempt to make contact with the subject of an 11-year-old boy, diagnosed with Schizoaffective Disorder and inhabiting a body marked by the jouissance of the Other that knows no limits and has to fight in order to find them. It describes a counselor's attempt to listen beyond the obsessive and narcissistic defenses of an otherwise powerless boy and to provide a venue for symbolization through play of that, which cannot be spoken about. What was Real and impossible for verbalization found its way to the symbolic order in the encounter of the subject with the desire to know of the counselor.

The presentation includes drawings, produced by the patient in the course of the treatment, that mark the developments of the unconscious image of his body from the depths of psychosis to the space of the social link. The paper also poses questions regarding the early psychoanalytic treatment of childhood psychosis as well as the early prevention and intervention of psychotic illness in children from a Lacanian psychoanalytic perspective. It raises the questions of diagnosis of childhood psychosis and explores the symptom as the voice of the subject addressed to the Other.

C. Emily B. Ogden, PhD. *Thinking and Being in the Hospital: The Psychodynamic Inpatient Group*

Research on the exacerbating effects that psychiatric hospitalization has on patients has been present in the field since critical psychiatry first appeared (Laing, 1960; Szasz, 1987). Many clinics and hospitals, however, have clung to the medical model of mental illness, and have persevered in their outdated and dehumanizing modes of treatment. Psychotherapy groups on inpatient psychiatric wards have the potential to serve as a reflective space for patients.

Vignettes are provided from the psychodynamic psychotherapy group that the author runs on a short-term inpatient psychiatric ward. The group's content and process illustrate the patients' desire to understand the meaning of their symptoms and subsequent hospitalization. The psychodynamic group (Bion, 1961) offers space for the leader to make interpretations that aim to metabolize the unthinkable experience of being a "mental patient". This theoretical understanding and practice of groups adds a necessary dimension to what have historically been symptom management or psychoeducational inpatient groups, which can have the destructive effect of further distancing the patient from his or her own suffering.

I use Kleinian theory to argue that psychodynamically-oriented group interventions allow patients to move from the paranoid-schizoid position of isolation of affect and avoidance to a depressive position of being able to locate self in relation to the patient role. The patient's chance to reflect on his experience while in the hospital is the beginning of a longer process of the patient integrating his psychiatric crisis into his life narrative and identifying his suffering as a valid aspect of his self system.

The author seeks to dispel the myth that short-term psychiatric inpatients cannot tolerate psychodynamic interventions, and that interventions aimed at encouraging the subjectivity of patients while in the hospital is integral to the treatment of these individuals.

D. Trisha Ready, PhD. *Where Marshall Mathers Matters More*

This presentation will focus on the use of self-selected music on a portable I-Pod stereo system for patients experiencing psychosis as a means of helping patients tolerate the stress of being in a hospital and to help patients manage voices, as well as overwhelming emotional states. This writer has been facilitating psychodynamic music-based groups with patients on the acute unit of a psychiatric hospital for the past 2.5 years. She has also focused individually with patients on the use of music as a means of therapeutic connection, expression and containment. Self-selected music can serve as a bridge and a subterranean passageway between the inner world of the patient and the therapist's inner world. This therapeutic resonance, or linking, is similar to attachment/attunement dynamics between infant and caregiver, with the overarching concept of music serving as a kind of auxiliary mother.

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The work of such psychological theorists as Winnicott, Beebe, Trevarthen, and Bion will be explored, as will the work of ethnomusicologists, psycho-biologists and neurobiologists who posit that music is our first language, and that the urge to attach and socially bond is historically our first urge toward music. Vignettes and examples from individual and group sessions featuring patients using self-selected music to help manage voices, tolerate distress, and express affect will be presented. These vignettes will illustrate song choice (from Eminem to Creedence Clearwater Revival to Bach) as a form of communication, and as an initial attempt to cope with affect. We will also explore several case studies focused on using self-selected music as a means to build a therapeutic connection with patients in early stage psychosis. This presentation will explore how some implicit memories may be more accessible through music than speech, such as may be the case for people who have experienced early, and ineffable childhood trauma.

Sunday, October 28
Concurrent One-Hour Papers

A. Brian Koehler, PhD. *What I Have Learned from Long-Term Relational Psychosis Psychotherapy and Social Neuroscience Research: Challenges and Therapeutic Efficacy*

The author will present his experience in working with a large number of persons diagnosed with psychotic and borderline disorders in long-term relational psychosis psychotherapy, particularly the challenges and difficulties involved, as well as the opportunities for therapeutic action and efficacy. Relational psychosis psychotherapy will be described, as will relevant research in social neuroscience, including research on the dynamic social genome and epigenome. An integration will be attempted along the lines of therapeutic efficacy.

B. Patricia L. Gibbs, PhD. *Pre-Verbal Realities: Artistic Primacy in the Contemporary Psychoanalytic Treatment of Psychosis*

I will be discussing what I call "Artistic Primacy" in the treatments of hospitalized and out-patient borderline, psychotic and schizophrenic patients. We will view the artwork and verbal psychotherapy passages from several individuals. Contemporary psychoanalytic treatments for psychosis often utilize creative therapies that do not focus exclusively on verbal psychotherapy. I will argue that this "Artistic Primacy" is essential in the successful treatment of these conditions.

Because an understanding of attachment theory and object relations development is crucial to understanding these contemporary treatments, I will begin with a brief overview of object relations research. The initial developmentally normal merged sense of self and other is retained over the lifespan to a greater or lesser extent in all of us. Psychotically organized patients hold onto this subjective state by enlisting psychotic defenses of denial and infantile omnipotence to retain the blissful union with the other, and resist the reality of separation and loss.

The one hour presentation will consist of digital reproductions of patient artwork. The artwork was collected from my work in the in-patient ward of the Detroit Psychiatric Institute, a Detroit-area Community Support Clinic for psychotic patients living in group homes, and from long-term outpatient psychoanalytic psychotherapy and art therapy from my own private practice. The therapeutic process of techniques privileging Artistic Primacy will be followed through several case summaries which will include artwork and verbal exchanges. Finally, the confluence of factors that I believe laid the groundwork for these successful pre-verbal therapies privileging Artistic Primacy will be reviewed during the slide presentation. During the 15 minute Discussion it will be possible to review artwork that reveals the diagnostic features of psychotic functioning, such as symbiotic- relatedness, paranoia, permeable ego boundaries, grandiosity, thought and identity fragmentation, suicidal ideation, and the failure to grieve.

C. Paul S. Saks, PhD and Maria Tsepilovan, MS.

In the Forests of the Night: Psychodynamic Treatment of Schizophrenia Through the Lens of Matte-Blanco's Bi-Logic

The title of this paper takes its inspiration from Blake's The Tyger, and the notion of "fearful symmetry" as a way to conceptualize the inner world and experience of psychosis. In his six years of working with an inpatient population diagnosed with severe psychotic disorders, the primary author of this paper has found Ignacio Matte-Blanco's work with bi-logic and symmetrical experience to provide an invaluable matrix for beginning to understand the language and symbols of psychotic thought process while working collaboratively with those whom are often regarded as untreatable. In seeing psychosis as a symmetrical fusion of time, space and identity, the author has been able to step into "the forest of the night" and create a point of highly personal therapeutic contact through language, art and ritual. The author will provide case material to highlight the therapy.

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D. Paris Williams, PhD.

An Exploration of the Existential Underpinnings of the Psychotic Process, From Onset to Full Recovery

The purpose of this presentation is to present the research carried out in 2010 that culminated in the presenter's doctoral dissertation. The aim of this research was to explore the psychotic process at the most fundamental level of human experience, with the hope that such an inquiry may offer some guidelines and perhaps even a more or less universal map that can be of service to others struggle with psychosis.

Qualitative multiple-case study methodology was used to inquire into the experience of six participants who had suffered from long-term psychosis and who are now considered to be fully recovered. Data analysis consisted of developing individual and cross case themes for each of six prefigured categories: description of the anomalous experiences, the onset and deepening of psychosis, recovery, lasting personal paradigm shifts, lasting benefits, and lasting harms. After exhaustive analysis of the data, a theoretical model was formulated that assisted in discussing the implications of the data. The results revealed that all six participants had striking parallels in their experiences with regard to all six categories of experience, with the most central implications as follow: an overwhelming existential threat to the self apparently played an important role in the onset of psychosis; the psychotic process was likely initiated by the psyche as an attempt to regain equilibrium in the face of this threat; recovery was primarily assisted by reconnecting with hope, meaning, a sense of agency, and the cultivation of healthy relationships; psychiatry generally caused significantly more harm than benefit in the process of recovery; and the successful resolution of the psychotic process involved a profound reorganization of the self along with significantly more lasting benefits than harms.

Concurrent Panels

A. Michael O'Loughlin, PhD, Patrick B. Kavanaugh, PhD and Ingo Lambrecht, PhD

Psychoanalyst as Shaman: Creative Engagement: Integrating Past and Present Wisdoms

The healer is an archetypal figure that has been with us for most of recorded history, acting as an intermediary between the world of the flesh and the world of the spirit. In some ways, the psychoanalyst of today takes up the position of the shaman of indigenous cultures, Charged with the ability to creatively engage with inchoate forces and unformulated experience, the clinician needs to be able to attune his or her unconscious to these forces and trust in what ensues. For the psychoanalyst, much like the shaman, our ability to be creatively engaged, through our reverie and dreams, with inchoate and unspeakable experiences provides a leading edge in our work with our patients. In our scientistic culture, pragmatic reality is overvalued despite our knowledge that reality can be like shifting sands, depending on one's vantage point. How then, we meet respectfully those who come to us weathering what one of patient calls 'the dark night of the soul' perhaps requires us to step back from our medicalized culture and to appreciate the wisdom of indigenous healers as we undertake the difficult journeys required.

B. Gregory Concodora, MA, MEd, Robert Foltz, PsyD and Peter Myers, PsyD.

Storm and Stress: Understanding and Facilitating Effective Relationships with Adolescents Diagnosed as Psychotic

Clinical work with adolescents has long been identified as one of the more difficult endeavors within psychological practice. In cases where the adolescent in question has demonstrated severe levels of psychopathology these difficulties have been noted to multiply, causing many therapeutic professionals to shy away from such work. And when the patient has been identified as experiencing symptomatology associated with psychotic functioning, along with the conclusion that intervention is likely to provide little benefit there is also often the appraisal that such persons are unable to form relationships with care workers. This state of affairs has led to inadequate intervention opportunities for adolescents demonstrating psychotic symptoms, overreliance on medication regimens and behavioral management techniques, and a significant lack of optimism with regard to prognosis.

This panel discussion will explore the development and progression of human relationships between clinical staff and adolescents diagnosed with psychotic disorders within residential treatment settings. It will include two doctoral level clinicians with over 20 years of combined experience working at residential treatment facilities within the Chicagoland area. Topics covered will include the subjective experiences of adolescents diagnosed with psychotic disorders, the nature of the therapeutic relationship, and experiences of transferrence and countertransferrence.

C. Ira Steinman, MD and David Garfield, MD.

In Depth: The Development of the Self During the Intensive Psychotherapy of Schizophrenia

The Intensive Psychotherapy of schizophrenia and delusional disorders is hardly practiced and rarely taught. Yet such a therapeutic approach may succeed and cure severely disturbed schizophrenic patients. To demonstrate the efficacy of an Intensive Psychotherapy and the attendant changes in the Self, several severely ill schizophrenic patients will be presented in depth.

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One had been heavily medicated with antipsychotics. given ECT, and repeatedly hospitalized for seven years. Diagnosed schizophrenic on psychological testing , the patient has been off antipsychotic medication and free of psychotic thought, hallucinations, delusions and behavior for more than thirty years since engaging with one of us (Steinman) in an Intensive Psychotherapy. Another was considered catatonic schizophrenic, yet functions in the community off all medication. Another came directly from the hospital for the criminally insane, against medical advice. Still another had multiple suicide attempts while pursued by voices; she has been symptom free for more than 20 years. These happy conclusions are the result of an Intensive Psychotherapy of schizophrenia, as made amply clear by David Garfield's analytic commentary and historical perspective on these highly successful psychotherapies. This Panel will teach the benefits and the methods of Intensive Psychotherapy, with Steinman presenting the psychotherapy and Garfield doing the analytic commentary and exegesis. Our focus will be on the development of the Self during the course of an Intensive Psychotherapy of schizophrenia. Our forthcoming book, when finished, will have the same title as this presentation.

D. Diana Semmelhack, PsyD, Larry Ende, MSW, PhD and Clive Hazell, PhD, DN

Psychotic Thinking in Our Social Groups

A group in a psychotic-like state can be a devastating phenomenon. We are sometimes shocked to hear of groups that are said to take extreme and irrational actions, radically undermining the values on which they had previously relied. The Inquisition and the Holocaust present horrifying examples of this. A similar pattern was followed when American soldiers designed humiliating tortures for prisoners at Iraq's Abu Ghraib prison. Evidence for psychotic-like thinking is also present in our mental institutions, which frequently perpetuate psychopathology in psychotic individuals rather than treat it. Special attention will be given to how psychotic tendencies in these institutions can be harnessed for creative rather than destructive purposes.

Writers often explain such events as a result of particular social conditions. We believe such conditions include psychotic-like thinking which, as Bion (1954) shows, already tends to characterize our social groups. Unspeakable events such as the Inquisition or the tortures at Abu Ghraib can then be seen to occur not only because unusual circumstances have led a group to become irrational, but also because these circumstances have mobilized the psychotic-like thinking already inherent in our social groups.

An everyday example of a group psychosis is when members hold a rigidly unquestioned (i.e. delusional) belief in the superiority or need for precedence of their own group. Under ordinary circumstances, this belief may not seem to be damaging to the group. (Similarly, an individual may think delusional thoughts and not appear to cause himself harm, especially if these thoughts are not put into action.) Under stressful circumstances, however, a psychotic process in a group, often defending against intense anxiety, may come to play a dominant role and dramatically interfere with the group's functioning. A group can avoid a catastrophe by keeping a check on its psychotic thinking.

This discussion will utilize lecture, demonstration and discussion to illustrate the core concepts related to the psychotic process in social groups.

Honoree Address: James B. Gottstein, Esq.

A Human Rights Lawyer's Perspective On The Mental Health System

It has become increasingly clear that drug company dissembling regarding the efficacy and safety of psychotropic drugs has resulted in massive harm, and caused an epidemic of people diagnosed with chronic mental illnesses and becoming debilitated. This talk will present a summary of this evidence and discuss the implications for clinicians.

Concurrent One-Hour Papers or 2 Half-Hour Papers

A. Françoise Davoine, PhD and Jean-Max Gaudillière PhD. *Beyond Lacan's Structural Approach of Psychosis*

Beyond Lacan's structural approach of psychosis, we met the depths of our patients' experience, thanks to the interdisciplinary tradition originated in Chicago around Jane Addams and others. Our own position in between being researchers in an advanced studies school for social sciences, and our psychodynamic work, as psychoanalysts for psychosis and traumas in public psychiatric hospitals and private practice, meets what H.S. Sullivan calls "the fusion of psychiatry and social sciences". This encounter seems to us particularly timely today, when research on a particular case in the long range, appears recently as a way of healing, also in the realm of biology. Clinical vignettes will illustrate our talk.

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B. Suying Ang. *Co-constructing Personal Narratives Towards Recovery Amongst Peers*

This presentation is a reflection on a discourse of meaning making that took place during a 4-session, once weekly peer support closed group, under the aegis of the Early Psychosis Intervention Programme (EPIP) in Singapore. It delved into struggles of participants who spoke about their bewilderment when first diagnosed with psychosis, thus impacting on their sense of selves. Facilitators were a peer support specialist with lived experience of psychosis and a case manager from the EPIP service.

Illness narratives and how it affected one's identity took up a large part of the discussions with participants seeing psychosis as narrative wreckage to their lives. Some participants brought to the group implicit expectations of wanting to seek restitution with the chaos and fear they were experiencing in their lives while others, including the peer support specialist, spoke of their recovery process as quest narratives; in their ability to rise above their challenges to gain more strength and belief in themselves.

Other recovery-oriented themes like hope, coping and well-being were expanded with participants expressing social connectedness in their relationships outside and within the group in the process of healing even while they faced obstacles from the stigma, discrimination and oppression that took place within an Asian collectivistic culture. Participants took on a dual perspective of being a wounded storyteller and a wounded emphatic healer in the group. The idea that having psychosis is one of the many aspects of their 'selves' is then reinforced.

The use of a 'here and now' approach of group facilitation and the involvement of a peer specialist encouraged self-disclosure and sharing. The presenter will also further reflect on her position of being without a lived experience of psychosis as she journeyed with the group into making contact with the depths.

Jagan s/o Rama Sendren.

Integrating Peer Support Specialists into Social Skills Training for Clients in Early Psychosis Intervention Programme

Background: EPIP was initiated in April, 2001 under the auspices of the Ministry of Health (MOH), Singapore. The programme includes medication management, psychological and psychosocial interventions for a period of two years by a multidisciplinary team. Suitable clients are selected for social skills training which is co-facilitated by case managers and peer support specialists. The inclusion of the peer support specialists in providing support for the clients started in January 2010 to instill hope through encouragement. Studies have shown that peer support groups are useful intervention for people suffering from psychosis by improving their social network (Castelein, et. al., 2008). In another study, Forchuk et al (2005) found that participants who received peer support demonstrated improved social support, enhanced social skills and better social functioning.

Aim: To look into the impact of integrating peer support specialists into social skills training for clients in the Early Psychosis Intervention Programme (EPIP), Singapore

Method: Focus group was conducted at the end of the 6 weekly training sessions to gather feedback on the impact that peer support specialists had on clients who attended social skills training. There were a total of 7 participants of which 2 were males and 5 females with a mean age of 28years old.

Result: The respondents felt supported by the peer support specialist's guidance, could relate and share about having similar illness. Peer support specialists contributed by making the clients feel encouraged and motivated to achieve their objective (s) of attending the social skills training.

Conclusion: The findings provide evidence that peer support specialists' involvement in social skills training had positive psychological impacts on the clients. Further investigations could be devoted to determine if the impact was due to ability to relate with peer support specialists or because peer support specialists were seen as role models.

C. Jeremy Ridenour, MPsy. *Psychodynamic Treatment and Model of Schizotypal Personality Disorder*

This paper will focus on the psychotherapeutic treatment of schizotypal personality disorder (SPD). SPD is the least treated of all the personality disorders (Gabbard, 2005); consequently, there are a lack of useful theoretical models and treatment approaches when working with this group of individuals. Of particular interest are the cognitive and disorganized symptoms of SPD, including: paranoia, odd thinking and speech, magical thinking, ideas of reference, odd behavior or appearance, and ideas of reference (Raine et al., 1994). Modern structural theory's integrative approach recognizes how ego deficits and intrapsychic conflicts explain psychological phenomena. I discuss how to address the positive and disorganized symptoms of SPD in the context of ego supportive psychotherapy (Stone, 1985) conceptualized through the lens of modern structural theory (Druck, 2011).

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First, I will highlight the importance of emotional deficits (Kerns, 2005) in schizotypy and how they are related to the positive and disorganized features of the syndrome. I will argue that focusing on the role of emotions with schizotypal individuals can help improve reality testing and judgment. Second, I will describe the role of conflict and defense, along with the weak inner ego boundaries and how these contribute to the compromised reality testing of the schizotypal individual. Third, I will analyze the cognitive and disorganized features of SPD from the perspective of primary process material and primitive defense mechanisms. Finally, I will evaluate whether modern structural theory is the most effective way to understand and to treat individuals with SPD in psychotherapy. I will present the long-term treatment of Ms. X who suffered from SPD in order to describe the various interventions I used to minimize the impact of positive and disorganized schizotypal symptoms along with a discussion of how I conceptualized her problems from perspective of modern structural theory.

D. David Downing, PsyD, ABPP

On the Demise of Delusion: Working with Certain Vicissitudes in the Aftermath of Psychotic Collapse

Considerable attention is given, understandably, to the treatment of psychotic persons at the point when the spectrum of symptoms [positive, negative] is most in evidence. What has received a lesser degree of focus has been in the aftermath of the more acute phases of the onset of psychosis and associated treatment. For purposes of this paper, the author will focus especially on the phenomenon of delusion. Whilst offering a perspective on working with delusions during the period of acute crisis, and subsequent elaborations, especial focus will be given to the work in the space wherein the delusion begins to dissipate, and the state of the patient in relation to its demise.

Many contemporary structures and models for treatment, when not coercive and highly controlling, still generally employ, in the main, exhortative, intrusive, 'educative' methods and often take place in highly-structured psycho-social rehabilitation programs. While many psychotic patients may well be helped by such approaches, the fact that large numbers are repeatedly hospitalised, over-medicated, and come to languish in 'human warehouses', makes it obvious that these interventions do not arrest the psychoses or improve the situations of a great many patients.

Unlike the usual current forms of treatment that attempt to control psychotic symptoms, like many psychoanalysts, the presenter approaches the patient in an entirely different way. Instead of viewing the delusion as the irrational by-product of a disordered brain, he views the nature of delusion as containing a valuable record of what disaster befell the subject. By means of persistent and considered listening, this record can be extracted from the delusion, and the patient assisted to assimilate this new knowledge. When this occurs, the individual begins a journey to take leave of his psychosis and become someone who can take his place in a world that had given up on him, and from which he had withdrawn.

It has been observed that a number of individuals then experience a different crisis of sorts, usually marked by considerable despondency or even clinical depression. Although the patient may now feel [re]connected with his or her personal narrative, and begin to feel themselves as having 'returned' to their Self, something eludes them, and is felt to be at a remove – the cohering and salvific functions afforded by the delusion. A period of re-viewing the delusion[s] in this new light is important to undertake with the patient, as opposed to assume that, in the absence of 'the symptom', all is well [in this regard, the pragmatism of American mental health models, including psychoanalysis, with an emphasis on adaptation to social norms and reality can hinder the clinician working within this space.]

Vignettes of two psychotic persons will be offered, illustrating the depressive aftermath of the demise of delusion. In this period, the patient is afforded a new opportunity for greater insight and to re-appropriate aspects of the self that, whilst psychotic perhaps, have represented something of value and assisted in lessening the agonies associated with the collapse into psychosis.

Concurrent One-Hour Papers

A. Ron Coleman. *Victoria Conn Memorial Lecture: Hearing Voices: What's the Problem?*

In this presentation I will explore whether the voices that people hear are actually the problem. The research of Romme and Escher concluded that the vast majority of people who were diagnosed with a range of mental health problems clearly rooted their voice hearing experience in what had happened in their lives. Given that that this research has now been replicated with similar outcomes the challenge for us it answer not only what is the problem, but what can we do about it? The main focus of the session will be to give participants a taste of the types of work that can be used with voice hearers that creates the opportunity for voice hearers to move on in their lives. Drawing on my own experience as a voice hearer and the work I have done with other voices hearers I will show how the process of working with voice hearers can be developed.

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B. Mark Richardson, MA. *Disorder or an Order of its Own: Analysis and Interpretation of Incoherent Psychotic Speech*

That speech and other actions are imbued with meaning is a fundamental tenet of psychoanalytic thought (Freud, 1901; Jung, 1914). Furthermore, to consider psychosis within a psychoanalytic frame is to presume that "psychotic phenomena make sense" (Castoriadis, 1996, p. 931; Freud, 1911/1963; Karon & VandenBos, 1994). While many have sought the meaning of sensory hallucinations and delusions (Arieti, 1974; Atwood, 2012; Karon & VandenBos, 1994), fewer have demonstrated a similar degree of interest and ingenuity in the analysis and interpretation of very disorganized psychotic speech (Bion, 1967; Lysaker & Gumley, 2009; Szasz, 1993), also known as incoherence (Andreasen, 1986) or word salad (Arieti, 1974). This is due in part to the absence of a useful mechanism for decoding what most experience as incomprehensible speech (Chaika, 1990; Rochester, Martin, & Thurston, 1977). Nevertheless, therapists are encouraged to persevere in the discovery of meaning (Karon & VandenBos, 1994).

In my paper, I will introduce a framework for developing the meaning of incoherent psychotic speech. Comprehension of incoherent psychotic speech is significantly challenged because the utterances do not conform to linguistic rules, particularly rules of syntax (Andreasen, 1986; Chaika, 1990). Proceeding from a psychoanalytic perspective, the "erroneous application of syntactic rules" (Chaika, 1974, p. 267) found in incoherent psychotic speech is reframed as symbolic alterations in the structure of language (Lacan, 1956; Spero, 1992). Analysis of syntax is therefore proposed, not only because its disruption is central to incoherence, but because this particular stratum of linguistic structure presents an opportunity to integrate linguistics and cognitive science with psychoanalytic theory. Informed by the work of Steven Pinker (2007) and Ray Jackendoff (2002) exploring the correlates of linguistic structures and thought, I will demonstrate how the comprehensibility of incoherent psychotic speech may be increased when syntactic structure is analyzed and interpreted in light of mentalistic models of language.

C. David W. Wilson, MEd. *The Role of the Transference as a Therapeutic Tool to Address Active Substance Abuse in the Treatment of Psychosis and Severe Mental Disorders*

In any psychotherapy we are confronted with significant difficulties in understanding as we attempt to work together with our patients. Patients who also misuse substances present us with additional levels of complexity. Not all models of psychotherapy readily adapt to the issues raised when patients may also be actively using substances of abuse. Frequently models of treatment of mental disturbance and substance misuse treatment are incompatible or contradictory. Variable and shifting mood and self states with concomitant impaired comprehension interfere with attempts to communicate in a coherent way that extend beyond periods of acute intoxication. Attempting to solve problems by substance use rather than verbalization inhibits change and maintains self-destructive patterns. Our attempts to understand by transference or mentalization may be insufficient and make it difficult to establish a reasonable level of understanding and assess the effects of our treatment efforts.

Many suggest that the interference introduced by substance use issues make it necessary to refer patients for treatments primarily designed for substance use before psychotherapeutic work directed to mental functioning can then begin. However, many patients fail to follow through with additional referrals and receive treatment from neither system.

In this paper a transference based system of treatment will be presented that will enable professionals to work productively and successfully with patients presenting with severe mental disorders and substance abuse problems. The emphasis will be upon the successful resolution of complicated clinical encounters in which it is revealed that denied or previously undisclosed substance use has been ongoing or when patients attend in an intoxicated state. Clinical examples from the presenter's practice will be discussed.

D. Carina Håkansson, Lic. Psychotherapist. *Ordinary Life Therapy.*

I will tell about practice and research I have been a part of during the last 25 years in a collaborative work between family homes (a kind of foster homes), those we call clients and their families and professional helpers.

Family Care Foundation originated from an idea to try together with others to create space for change; by talking, acting and finding ways to live in peace with oneself and others. Those we call clients come to our organization since they have given up hope, they can't find their own voice or way of living life. Many have been in institutions for many years, they are described in terms of psychiatric diagnosis and prescribed medication. We work with young people, adults and parents coming together with their children.

Over the years we have experienced the importance of inviting people, including and counting on each and every one, yet in different ways. By working together we have found out that many of those defined hopeless are indeed not hopeless, but humans as you and me.

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Just as life itself our work is not without struggling, doubts and hard times, but it is also full of joy, trust and love. And it has convinced me that there are no easy ways, but lots of possibilities as long as we both work together and take a personal responsibility for ourselves and each other.

Nowadays our organization is part of a huge international network with people sharing the same visions and ideas about how to create a better world by taking part in our different experiences, stories and ways of living.

Concurrent One-Hour Papers (1 CE hour)

A. Robert Foltz, PsyD. *The Adolescent Experience of Antipsychotic Medications: Results from the ASET Study*

The use of antipsychotic medications has skyrocketed in recent years. As part of this use, children and adolescents are increasingly prescribed these powerful medications in an effort to "treat" psychotic symptoms, behavioral difficulties and emotional dysregulation. But the widespread use of these medications in young people is not firmly established with an "evidence base." As a result, the effectiveness of these interventions is largely based on adult studies or anecdotal reports.

The Adolescent Subjective Experience of Treatment (ASET) study surveyed 74 adolescents related to their perceptions of treatment effectiveness. The majority of these severely troubled youth are prescribed antipsychotic medications. This presentation will review the current trends in antipsychotic use, and highlight the perceptions of effectiveness, as articulated in the ASET study, by adolescents. While some of these participants were given diagnoses reflecting a psychotic disorder, across all youth prescribed antipsychotics, many study participants had an overall negative impression of being on medications. Their perceptions of medication effectiveness related to specific symptoms will also be examined.

B. David Garfield, MD and Jeff Mirsky, MD.

Subtypes of Pathological Accommodation in Psychosis: Black Swan *and* Shine

Through illustrations from two movies: Black Swan and Shine, two different types of patholol gical accommodation can be discerned that lead to psychological vulnerability to psychosis. In Black Swan, Nina's existential existence required her to meet overwhelming mirroring selfobject needs of her mother which subsequently left the daughter with pervasive developmental arrest. In the movie Shine, the father-son relationship depicts the pervasive use of the son for the father's idealizing selfobject needs which leaves the son vulnerable to his manic-catatonic breakdown. The films depict the role of the pursuit of perfection and the fall into psychosis at the point of achievement of lifelong goals in these two parallel but very different same sex parent problems--one which leads to death and the other to recovery.

C. Garth Amundson, PsyD. *Tor-Mentors: Delusional Companions, Fellow Travelers, Guides, Masters, and Other Daemonic Figures Encountered in the Psychoanalytic Treatment of Teenagers and Young Adults*

This paper addresses the meaning(s), developmental role(s), and treatment(s) of the phenomenon of delusional subpersonalities existing within the mind of the teenager or young adult. Typically experienced by the patient as daemonic companions, tormentors/mentors, and/or helpmates, these delusional entities serve numerous developmental and/or defensive functions within the psyche. While diagnostically "psychotic" in nature, these figures do not dominate the entire personality, as in the case of schizophrenia and other, more serious psychotic disorders, but, rather, are circumscribed in nature, acting as defensive responses to specific developmental failures and challenges. To my knowledge, this is a subcategory of psychotic phenomena that has never been discussed in depth in the literature and hence is poorly understood; this paper is a preliminary attempt to articulate the nature of this syndrome.

The daemonic inner objects are usually hidden from detection behind a façade of superficial normalcy and/or passable social adaptation. They are present in the young person's psychic economy as directors of certain aspects thought, intentionality, and action. They may be single or multiple entities, each one of which may subdivide into multiple beings or become united with others across time. They are generally described by the patient as existing as uncanny presences, eerie, ghost-like beings about whose objective existence the young person is more or less convinced based largely on intuition rather than on the experience of auditory or other hallucinatory events. However, on a positive note, the circumscribed nature of the delusions means that the young person usually retain a semblance of self-critical doubt about this intuition, one that can be worked with therapeutically over time.

These inner objects act as perverse "mentors", offering various forms of modeling of effective social behavior, seductions to engage in psychopathic acts, and/or warnings of others' secret intentions, among other directives and (alleged) insights. The young person's relationship to the daemonic object is highly ambivalent and organized along sadomasochistic lines: hence, the daemonic presence is generally perceived by the young person as benevolent, sadistic, or, most often, some combination of the two, and, further, is encountered experientially with various mixtures of allure, idealization, dread, and/or shame.

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Speaking metapsychologically, I propose that the delusional inner figures are created from the operation of splitting and/or mild dissociative phenomena, many of which are associated with the operation of hysterical defenses as described by Freud (1893/1908). The daemonic internal objects act as fantasied "containers" of intolerable affects, serving to help the patient avoid, isolate, and make controllable (through concretization) the upsurge of heretofore repressed need, desire, and fantasy initially occurring in early adolescence, particularly that related to the depressive affects related to separation anxiety and uncontainable sexual and aggressive feelings. I have invariably encountered the presence of an objectively unempathic, emotionally shallow home environment in my patients who suffer from this form of delusional disorder, what I deem a key factor in the genesis of exaggerated splitting defenses.

The theories of Melanie Klein (1975) and W.R.D. Fairbairn (1952/2006) are particularly useful in conceptualizing the genesis of these delusional figures and settling on helpful technical stances toward the young patient beset by this condition.

D. Charles Turk, MD. *You've Done it Your Way for Years – Now it's Our Turn.*

This presentation is organized around a clinical case of a very disturbed young woman who had been continuously medicated for seven years with little improvement in her dysfunctional state. From this derives the first part of the title: "Your way" – a reference to the prevailing contemporary treatment of psychosis based on a "scientistic" ideology. The young woman's family, seeking alternative care, arrived with a request that their daughter's medication be discontinued and that she become engaged in another form of treatment. "Our turn" refers to that form, an approach oriented along the axis of a search for her humanity and potential agency, in contradistinction to one that regards her simply as an object of care.

The case will serve as a clinical reference point to illustrate the theoretic basis of the work at "388" - the psychoanalytic treatment center for young adults developed by the analysts at GIFRIC, in Quebec City. When the young woman encountered the first of the expectable crises intrinsic to such treatment, she had to be hospitalized. The contrast between current hospital care and an alternative setting will be drawn and discussed with respect to the difficulty of attempting to construct a frame within which to receive and work with delusion - as distinct from attempting to suppress it by means of medication.

Delusion is viewed as symptomatic, not of a disordered brain producing cognitive distortion, but rather as an attempted explanation for a psychic disaster as well as the formulation of a solution to it, and where its failure to provide a solution is manifest in recurrent crises. The dearth of settings that can sustain a "holding environment" to support such psychoanalytic work requires a response.

ISPS-US would like to thank the following people for their generous donations (beyond dues) for 2013:

Ronald Abramson, MD
Jessica Arenella, PhD
Kenneth Blatt, MD
in memory of Joan Shea
Thomas E. Fink, PhD
Patricia L. Gibbs, PhD
Joanne Greenberg, DHL
in memory of Frieda Fromm-Reichmann
Maurine Kelber Kelly, PhD
in memory of Johanna Krout Tabin
Kay Ellen Lowenthal, JD
Alice Lombardo Maher, MD
Eric R. Marcus, MD
in memory of Dr. Harry Albert
Gertrude Pollitt, DPsa
Manny Rich, LCSW, PhD, BCD
John A. Russell, MD
in memory of Wayne Fenton
Althea Schoen, MSW, LCSW,
in memory of Harold Levin
Constance Shope, PhD
Ann-Louise S. Silver, MD
Stuart B. Silver, MD
Rita P. Sussman, PhD
in memory of Bertram Cohler, Ph.D.
Miltiades L. Zaphiropoulos, MD

Thanks so much for your generosity. We count on your donations! To make a tax-deductible contribution to ISPS-US, please use the membership form in this issue or click the donation button on our website, www.isps-us.org. One area in which donations are especially needed is the fund to allow low-income people to attend the annual meeting.

Note: If you made a donation but your name is not included, it's because you did not give us permission to print your name. Please let us know if we may thank you publicly!

ISPS-US is a 501(c)(3) nonprofit organization.

Executive Committee News

Nancy Burke ISPS-US Vice President; Melbourne Declaration; Harassment Policy Adopted.

Welcome to Nancy Burke, who was appointed Vice President of ISPS-US in July. Nancy was program chair of the 2012 annual meeting. She replaces Marty Cosgro, who has stepped down to pursue professional and personal activities. Marty has given many years of service to ISPS-US. In addition to his recent post, Marty served as Webmaster, program chair of the annual meeting at Santa Monica CA, and ISPS (Int.) Treasurer.

The executive committee approved making ISPS-US a signatory to the Melbourne Hearing Voices declaration. The declaration was launched at the World Hearing Voices Congress, in Melbourne AU, this November. Thank you to Berta Britz for representing ISPS-US at the Congress. In becoming a signatory, ISPS-US agrees to a "commitment to making changes in the organization to:

1. ensure it feels safe for people to talk about voices and other unusual experiences
2. work to enable increased hope, control and opportunity for people who hear voices and their families
3. listen to the experience of voice hearers
4. work with, rather than against, voices
5. ask about and support people to address past trauma
6. tackle myths and stigma about hearing voices
7. support people to build skills that empower them to change their relationship with voices
8. build this declaration into their planning processes until the changes are embedded.

ISPS-US has issued a formal statement on discrimination and harassment and instituted a Sexual Harassment Policy. Here are excerpts from the statement. The full statement and text of the policy and guidelines are on the website, www.isps-us.org

ISPS-US strictly prohibits discrimination of any kind on the basis of one's race, religion, gender, sexual orientation, disability or socio-economic status, or any other protected characteristic. Set forth below are the guidelines we expect everyone to follow:

1. Treat each employee, contractor, member, officer, volunteer and event attendee with respect and consideration.

2. ISPS-US encourages anyone who believes he or she is the victim of harassment by an ISPS-US employee, contractor, member, officer, volunteer or event attendee to notify at once any officer or other member of the Executive Council.

3. If you do not receive a satisfactory response or you feel uncomfortable, for whatever reason, discussing the problem with him or her, we encourage you to speak to another member of the Executive Council. You may also join the monthly conference call to bring up the issue, having asked the President that it be added to the agenda.

4. We will investigate the matter promptly and thoroughly to achieve a fair result. The member of the Executive Council must immediately bring the issue to the attention of the entire Executive Council, either by email or on the monthly conference call.

5. The President will make a detailed record of each complaint. Each complaint will be kept confidential to the extent feasible, unless the person making the complaint agrees that it may be discussed with others.

6. Any employee, contractor, member, officer, volunteer or event attendee who is found to have harassed any employee, contractor, member, officer, volunteer or event attendee or to have interfered in any way with that person's right to work in an

Thank you to Berta Britz for representing ISPS-US at the Melbourne World Hearing Voices Congress.

environment free from discrimination, may be subject to immediate discipline, including dismissal or expulsion from ISPS-US.

Sexual Harassment Policy

It is ISPS-US's policy to maintain a work place and organization free of sexual harassment from any source. Sexual harassment, whether committed by employees, contractors, members, officers, volunteers or event attendees, is strictly prohibited.

Sexual harassment does not refer to behavior or occasional compliments of a socially acceptable nature. It refers to sex-based behavior that is unwelcome, is personally offensive, fails to respect the rights of others, lowers morale, or interferes with work performance.

Any employee, contractor, member, officer, volunteer or event attendee who believes he/she has been subject to or has witnessed sexual harassment is strongly urged to immediately notify any officer or other member of the Executive Council.

ISPS-US 14th Annual Meeting
What's in a Name?
Emerging Perspectives on the Intersection of "Schizophrenia" and "Recovery"

OCTOBER 4-6, 2013
At the Hyatt Regency, New Brunswick, NJ
Two Albany Street, New Brunswick, NJ 08901

ABSTRACTS

Honoree Address
Daniel Fisher, MD, PhD
Dialogical Recovery Approach: Using Severe Emotional States (AKA Schizophrenia) for Self-Integration

I was diagnosed with schizophrenia at age 26 while carrying out research at NIMH on the neurotransmitters supposedly responsible for mental health conditions. Through four episodes of extreme emotional states for which I was hospitalized, I was able to integrate at a deep level. I became a psychiatrist in order to humanize the mental health system, but found that larger systemic change was needed. Through founding the National Empowerment Center and being a member of the White House Commission on Mental Health, I assisted many others with lived experience of recovery to construct an inspiring recovery paradigm as the basis for policies to replace the deadening maintenance model. I have also learned that recovery is enhanced by a positive re-framing of distress as potentially growth promoting. Part of such a re-framing is to move away from diagnoses to more narrative-based descriptions. If instead of an individually-based, illness model, the person experiencing distress and those close to them understand their so called symptoms are attempts at deep integration as described by John Weir Perry, then personal growth is possible. I propose a synthesis of recovery and dialogue, called a Dialogical Recovery Approach, consisting of a combination of Open Dialogue, Recovery Dialogues, and emotionalCPR. We advocates find the Finnish Open Dialogue description of distress as residing in the space between the members of a person's social network as more conducive to growth of all involved. I will describe the 2-year training program in Open Dialogue, which I completed at the Institute for Dialogical Practice, and the application of this approach in private practice. I will also discuss the application of dialogical principles in systems change through recovery dialogues in a community mental health center. Lastly I will discuss the use of emotionalCPR as a vehicle for public education in personal growth through application of dialogical principles by the general population.

Keynote Address
Debra Lampshire. *A 360 Degree View of the World: An Expansive Approach to Madness*

How do we respond when two conflicting world views collide? Is it possible to navigate safely though the possible misunderstandings and hostility which can arise when equally deeply entrenched and polarised views present? How do we hold the tension and act responsibly so as to extend the hand of compassion to initiate reconciliation and acceptance? What may we need to consider when endeavouring creating a mutually beneficial and productive relationship whilst establishing an environment conducive to recovery?

Chris Burford Memorial Lecture
Andrew Moskowitz, PhD
'What's in a name? Schizophrenia, Psychosis, Trauma, Dissociation, Recovery - which words hold the key to our future?

Just over 100 years ago, Eugen Bleuler coined the term Schizophrenia partly because he found Dementia Praecox too pessimistic. He thought that recovery was possible, even if a "hint of schizophrenia" would always remain. A compassionate man and concerned physician, Bleuler would hardly recognize what his concept has morphed into over the past century. Heavily emphasizing psychotic symptoms and highly stigmatizing, the current diagnosis was wisely jettisoned by ISPS last year. But dropping the term schizophrenia should not make us forget the other reason Bleuler chose the term – he thought these persons were suffering from a split mind. The links between dissociation and schizophrenia that Bleuler raised, along with the importance of childhood trauma, are now being fleshed out through research.

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In this talk, I will explore the historical and contemporary meanings of the terms schizophrenia, psychosis, trauma and dissociation, and the various ways in which they interact. I will suggest that, while there were good reasons ISPS dumped schizophrenia, the substitute "psychosis" is not without its conceptual and clinical limitations. Because whatever is unique to schizophrenia – or the "diagnosis formerly known as schizophrenia" – it's not psychotic symptoms. Losing the diagnosis makes it conceptually more difficult to characterize those persons who formerly met the diagnosis.

And finally, what about "recovery"? While the aims of the recovery movement, set against those of traditional psychiatry, are laudable, the term itself is restrictive. It begs the question "recovery from what"? Illness? What else does one recover from? "Recovery" primarily designates the state before psychosis as "less than" what comes after (and what came before). But is this really how we wish to conceptualize these experiences? Perhaps "recovery/discovery" movement would capture the spirit better?

This presentation will be a wide-ranging discussion and contemplation of these issues, leading to a consideration of which terms may point the field in a positive direction.

Victoria Conn Memorial Lecture

Jay Yudof, MS, CPRP *The Breadths and Strengths of Mental Health Peer Providers*

People living with a mental health illness have been working in the mental health service fields since time immemorial in various roles. Some labor at the front lines, disclosing or non-disclosing. Some are in leadership or research positions. The range of roles peer providers occupy, and their influence on the system, appears to be increasing. This introductory talk will address the breadth of peer provider roles, possible future directions, and issues of disclosure, integration, and career growth. We will briefly profile some leading peer providers.

Plenary Sessions

Town Hall Meeting with Brian Martindale, MD, FRCPsych, M Inst Psa

ISPS: New Name but Old Wine in a New Bottle? What is the future for ISPS-US within the ISPS international?

As Chair of ISPS I will present an international perspective on ISPS. My aim will be to inform US colleagues of the wider work of the organisation, the changes that it has undergone in the last two decades (including the name change) and suggest where we might be able to get to in the next two decades by working together. I will emphasise some of our organisation's strengths and some of our limitations.

The creation of local networks has been crucial to the transformation of ISPS, and the US networks are excellent examples of that transformation from the ISPS of the 1990s.

I will make some challenging comments about the current needs of networks to make better or clearer developmental plans and I will give plenty of time for participants to comment and make suggestions.

Brian Koehler, PhD

A Contemporary Overview of Evidence-Based Psychosocial Therapies in Psychotic Disorders (Schizophrenias and Bipolar Disorder)

A contemporary overview of psychological and psychosocial therapies for psychotic disorders, including the schizophrenias and bipolar disorder, will be presented. Both experimental (randomized controlled trials) and qualitative, quasi-experimental evidence will be discussed. This review will also include descriptions of such emerging psychosocial therapies as family focused therapy and interpersonal social rhythm therapy for bipolar disorder, compassion mind training, Open Dialogue, and acceptance and commitment therapy for the schizophrenias, and CBTp for both clinical disorders. Quasi-experimental evidence for psychodynamic therapies will also be covered. In addition, there will be a brief neuroimaging review of the effects of various kinds of psychotherapies on the brain, with implications for psychotic disorders.

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Conference Abstracts

Ronald Abramson, MD, J. Tyler Carpenter, PhD, Steven Nisenbaum, PhD, JD, Janet S. Richmond, MSW, Ronan Wolfsdorf, MSW: *Workshop presented by members of the Boston Area Group of ISPS-US.*

Psychological and Social Approaches to Treating Psychoses in Different Settings: The Effects of the Setting

Just as people who develop psychotic problems evolve these through various experiences, those of us who attempt to help such people recover through psychological and social approaches do our work in different settings. Each setting offers opportunities that enhance our work but also limitations that constrain and limit what we and our clients can accomplish.

We seek to present a workshop which will feature examples of approaches toward recovery in different settings, prison, physical culture, and private practice. Descriptions of the setting along with case examples will be presented with emphasis on the advantages this setting offers as well as the drawbacks.

Our plan is to leave plenty of time for discussion and our hope is that people who attend this workshop will feel free to share the experiences of their settings with advantages and disadvantages. It may be that from a lively discussion drawing on the experiences of all participants might emerge ways to cope with perceived limitations and enhance perceived advantages.

Individual Abstracts:

Abramson: *Presentation of Alexander*

I am presenting the case of Alexander, a 23 year old single man living partly at home with his parents and partly in a college dormitory. He was referred to me because he seemed odd and because he was at risk of suicide. His initial presentation was quite puzzling, but it has subsequently become clear that he has an Autistic Spectrum Disorder (ASD) and has developed psychotic phenomena in this context. He has emerged as a brilliant individual who lives behind a sort of raw fearful psychic (as distinct from solid) wall that separates him from other individuals. Unable to connect with other people, he erects representations of these other people behind his wall with whom he then communicates and relates. Since his "interpersonal" life is carried on between him and his representations, there is little reality testing, and so he is predisposed to psychotic thinking. He has been seeing me about once a week for three years. In my counter-transference, I tend to feel like a nervous piece of wood because forming a genuine connection with him feels impossible and he has had suicidal thinking, angry outbursts, and auditory hallucinations.

It is advantageous to see him in independent private practice because I am free to try various strategies for engagement. But it is disadvantageous because of the constraints of insurance coverage and because I am not part of a treatment team consisting of individuals with various backgrounds and skills that might form a better holding environment.

Carpenter: *Treatment in the Prison Setting*

Treatment in prisons is many things, both simple and complex, but above all it is a collective experience. None of it occurs in isolation from any other process by which it proceeds. This portion of the workshop presentation will consist of a framework for how one can think about working therapeutically in prisons. It will follow a well-established outline of comparative psychotherapy systems to set out the structure and contents of implementation. Audience participation and discussion will be part of the discussion.

Nisenbaum: *A New "Resilience" Language and Approach to Treatment in State Hospitals*

Inpatient programs for the mentally ill have generally reflected the ethos of one or more of the 5 influential paradigms and traditions in our understanding and efforts to provide services and protect against harm: 1) containment; 2) "moral treatment" in asylums; 3) psychodynamic therapies, and other treatments, rehabilitative therapies, and activities; therapeutic community and self-help paradigms; 4) cognitive behavioral contingency intervention programs; and 5) the biological (e.g., pharmacological, electroconvulsive, surgical) treatments. These each reflect particular assumptions about "mental illness" and human nature in conjunction with cultural and political values, as well as factors of available technology, costs, professionalizing, and competing demands. A New "Resilience" Language reflecting major changes in societal values and modern culture is now both possible, conducive to, and necessary to enhance efficacy and guide approaches in the early 21st Century. This portion of the panel presentation will consist of a framework for how one can think about this "Resilience Model" paradigm and preliminary observations from electronic audiovisual approaches to emotional coping, cognitive, and life skills for the seriously mentally ill and other patients in State Hospital and public inpatient facilities, working therapeutically in prisons. It will be augmented by an applicable set of epigrammatic principles for implementation. Audience participation and discussion will be part of the delivery.

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Richmond: *Emergency Department Setting*

Agitation is a common presentation in the emergency department, and is an acute behavioral emergency requiring immediate intervention. It may present on a continuum ranging from anxiety up to and including violence.

This workshop will address techniques of verbal de-escalation that the emergency clinician can quickly learn and implement as an alternative to seclusion and restraint. Ultimately, successful verbal de-escalation empowers the patient and improves staff morale and patient adherence, because it utilizes a non-coercive, patient-centered approach. Verbal de-escalation enhances the doctor-patient relationship, while seclusion and restraint require more staff and take more time to implement, and reinforce to the patient that the only way to resolve conflict is through physical means. The offering of medication can be considered part of verbal de-escalation, and methods of introducing the subject of taking medication can be done in increments.

This workshop is for the beginning or seasoned psychiatric clinician who is unfamiliar or uncomfortable with the intensity and urgency of a psychiatric emergency. Strategies of assessing and engaging verbally with agitated patients will be discussed, including offering of medications. These recommendations are in part based on the author's clinical experience and a consensus panel of emergency psychiatry clinicians (American Association for Emergency Psychiatry-AAEP).

Wolfsdorf: *Activity Based Group Therapy: Exercise and Sports*

Milieu treatment involving activity-based group therapy, especially exercise/sports, can help clients with psychotic disorders recompensate. Such therapy offers benefits re: mind-body vitality and unconscious interpersonal relating, whilst potentially obviating some of the dyadic intensity (and transferential challenges) of private session talk typically antecedent to recompensation. This session will review theories of regression in psychosis, anecdotal material: client motivation for non-talk based versus talk-based group therapy, the benefits of "play" for young adults, and thus the adjunctive (or preparatory) value of such engagement. The session aims to facilitate exploratory discussion through audience participation and sharing.

Berta Britz, MSW, ACSW, CPS

My Liberations

For me recovery is liberation. Liberation for me is moving from a state of disconnection and powerlessness to a state of connection and power. Marius Romme calls this "taking back the power or emancipation." As an American I associate "emancipation" with Lincoln's Emancipation Proclamation, something someone else declares for us; I use the term liberation because I view recovery as an experience one goes through personally, that no one can do for us or define for us. In my experience recovery required a social context to move from disconnection to connection – I needed to connect with myself, with other people, and with "God." For me this process began with the subjective reality of powerlessness. First, powerlessness in relation to my abusing caregivers as an infant and young child; later, powerlessness in relation to mental hospitals and other re-traumatizing experiences; and, for four decades, powerlessness in relation to the voices I heard. I experienced my most recent liberation six years ago when I learned about the World Hearing Voices Network approach to accepting and making sense of voices. I have accepted my voices as my own, am in ongoing dialogue with them, and accept responsibility for them. I own my power and am connected to others through love and hope.

Berta Britz, MSW, ACSW, CPS, Oryx Cohen, MPA, Lisa Forestell, Nev Jones, MA, Melissa McLean

Perspectives on the Hearing Voices Network Movement from 5 Facilitators of Hearing Voices Groups

Members of the panel will speak about the history and values of the Hearing Voices Movement (HVM) and its impact on their voices and extreme states work in the USA. Panelists from different regions of the country will discuss the progress, process, and challenges encountered in bringing a hearing voices network approach to their communities. They will discuss how professionals/allies can be best involved in the work of networks and groups and different strategies for collaboration, partnership and community outreach. There will be ample time for discussion and the panelists hope to promote substantive dialogue between voice hearers, peers, clinicians and other session attendees about the future of the HVM in the US.

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Marilyn Charles, PhD, ABPP

Working at the Edge: Meaning, Identity, and Idiosyncracy

Humans come into being in relation to other people and to the world as it has been defined for us. As the language of psychiatry has come to dominate over other possible ways of making meaning in the arenas of mental health and psychological distress, normal developmental processes can become invisible over concerns regarding possible "disease entities" that may be taking of the human mind and being. Lacan recognized how much is embedded in Language, initially offering a model in which the "Name of the Father" is privileged along with a normative, somewhat constrictive model for human development. In his later seminars, however, Lacan puts forward the suggestion that the laws of Language and the "Name of the Father" may be the neurotic solution to questions of existence and identity. In contrast, he suggests, the solution of the psychotic (or the artist) may be more idiosyncratic and, I would argue, potentially more creative. In this presentation, I will use the case of a young man who began to lose his mind in the process of trying to overthrow the Law of his father and install his own sense of values. As such, we can consider ways in which what might appear to be a psychotic diathesis may mark, instead, a turbulent struggle to establish and maintain an autonomous, creative identity. We can also consider the role of the therapist in establishing an environment in which that important work might be accomplished.

Gregory Concodora, MA, M.Ed.

From the Mouths of Babes: Adolescents Diagnosed as Psychotic Offer Their Perspectives on Human Relationships

Clinical work with adolescents has long been identified as a difficult endeavor within psychological practice. In cases where an adolescent has demonstrated severe psychopathology these difficulties have been noted to multiply, leading therapeutic professionals to shy away from such work. And when an adolescent has been identified as experiencing symptomatology associated with psychotic functioning, along with the conclusion that intervention is unlikely to provide significant benefit, there is also often the appraisal that such persons are unable to form useful relationships with care workers. This state of affairs has led to inadequate intervention opportunities for adolescents demonstrating psychotic symptoms, overreliance on medication regimens and behavioral management techniques, and a significant lack of optimism with regard to prognosis.

Despite these difficulties, there has been little interest within academic psychology to sit down with such persons and ask them what they think about issues related to self, the other, and human relationships so that professionals might learn more about why they seem to experience so much trouble with members of this population. Instead, researchers tend to prefer their own "expert" analyses rather than the opinions of this ignored and disregarded group, in the process missing tremendous insight into how these young men and women see themselves, others, and what really matters when forming connections between human beings.

This writer's dissertation project endeavored to give voice to this often marginalized and misunderstood population by engaging them in conversations about their ways of understanding and making meaning from human relationships. Phenomenologically based, semi-structured interviews were conducted with 6 adolescents between the ages of 16 and 19 who were in residential treatment at the time these conversations took place. This presentation will explore, using their own words, the ways in which these adolescents see themselves and their relationships with friends, family, and clinical care workers.

Mark Duffy, MSW, CPRP, Sandy Badmaev, Louis Blicharz, Jeanette Ellis, MA, Lois Miller, MSW, LSW, CPRP *Informed Choices (Making Informed Decisions about Your Treatment and Your Wellness Options)*

The panel will be made up of five persons (two users of mental health treatment and three providers of care) who made up the original learning and support group that developed the Informed Choices program.

The panel will present a description of the Informed Choices initiative at CSPNJ. Informed Choices is a learning and support program whose purpose is to provide education, support, and information about mental health treatment optimization and alternative approaches to wellness for persons who have the lived experience of mental illness and are users of mental health services. The mission is to help people in their recovery journey make choices for themselves that will improve their quality of life.

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The participation goals of the program are to:

• Develop skills in making informed treatment decisions in cooperation/consultation with providers including an individual's psychotropic medication prescriber

• Build knowledge about a variety of ways to get and stay well using the 8 dimensions of wellness:
-Emotional – Coping effectively with life and creating satisfying relationships
-Financial – Satisfaction with current and future financial situations
-Social – Developing a sense of connection, belonging, and a well-developed support system
-Spiritual – Expanding our sense of purpose and meaning in life
-Occupational – Personal satisfaction and enrichment derived from one's work
-Physical – Recognizing the need for physical activity, diet, sleep and nutrition
-Intellectual – Recognizing creative abilities and finding ways to expand knowledge and skills
-Environmental – Good health by occupying pleasant, stimulating environments that support well-being

• Learn how to ask questions about treatment
• Write a personal wellness plan
• Learn about systems change and advocacy to make that change happen

Kateryna Dukenski, MA

Application of Modern Psychoanalytic Technique to Overcoming Resistance in an Inpatient Psychotherapy Group

This paper introduces several modern psychoanalytic techniques and their application to group treatment with patients presenting with psychosis in an inpatient setting. Modern psychoanalytic approach to group psychotherapy, developed by Hyman Spotnitz, emphasized the therapist's use of his or her feelings induced by the group, as well as joining and reflecting rather than directly challenging group resistances. The author presents her experiences with the implementation of this approach in a local psychiatric hospital with patients who present with initial difficulty to be therapeutically engaged. The paper focuses on presenting techniques that allow resolving the resistance of group members to communicate their thoughts and feelings regarding their lives, their experiences on the unit, their reactions to each other and the group leaders. According to Spotnitz, just saying everything is a curative experience in itself, especially when this ability is compromised in case of severely mentally ill patients. The difficulty to communicate openly in the presented group was handled by group leaders by using the following modern psychoanalytic techniques: object-oriented questions, joining and reflecting resistance, emotional communication, consulting with the group, bridging and maturational interpretation. Based on the presented clinical work, the author argues that modern psychoanalytic techniques can be successfully implemented in an inpatient group setting with patients who are otherwise difficult to engage in most of therapeutic activities.

Larry Ende, MSW, PhD & Diana Semmelhack, PsyD, ABPP

The Importance of Social Interaction in Recovery

Jean-Max Gaudillière, PhD & Françoise Davoine, PhD

What to Do When the Tool with the Names is Broken?

People familiar with Ludwig Wittgenstein will easily recognize his compelling question, as expressed in the "Philosophical Investigations". But we will also confront this matter-of-fact situation with specific moments of the transference with madness and trauma. The principal outcome of it is: when it is impossible to name something, there is not another solution than to show it. To whom, if the addressee is an analyst? And with which tools could he/she answer that critical situation?

Patricia L. Gibbs, PhD

Re-naming, Re-reading and Re-thinking: Psychotic Depression and Its Treatment and Recovery

I will be considering three patients that I have treated in long-term psychotherapy or psychoanalysis who all struggled with typical features of psychotic depression. The central conceptualizations of psychoanalytic work that I have used to understand and now re-examine these long-term treatments are: Melanie Klein's work on mourning and manic defenses, Edith Jacobsen's work on the importance of superego development facilitating reality testing, and the contemporary clinical techniques centered on the use of projection identification and the countertransference in treating psychotic patients.

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In considering clinical vignettes from three different patients, I will examine the common features of psychotic depression that overlap clinical work and current research coming from fields both within, and outside of psychoanalysis. Thus, the outcome studies of recovery from severe abuse and trauma, PTSD, schizophrenia, and psychotic depression will be briefly noted. The questions I have asked myself, and will invite the audience to consider during the discussion period, will include: "What are we saying when we conclude someone cannot recover from any situation or mental disorder?" "How might this conclusion impact the therapist's countertransference – or unconscious identifications with the patient?" "What are we really saying when we conclude someone is 'unanalyzable'?" "What picture of the human condition results when we insist that psychological difficulties must be considered within the biomedical model of medication-only treatment?"

The presentation will focus on the power of the therapeutic alliance and the psychoanalytic transference/countertransference in achieving a "life worth living" – with or without the use of medication. The process of mourning, both in the analyst and the patient, will be highlighted in the clinical vignettes. Using treatment examples involving the mutative processes of mourning, I will demonstrates how manic grandiosity and the denial of human limits eventually gives way to improved judgment and the meaningful embrace of reality.

James E. Gorney, PhD

The Lost Tribe: Micro- and Macro-History in Recovery from Psychosis

The Oxford English Dictionary defines the word recover in the following manner: "To get back again into one's hands or possession; to regain possession of something lost or taken away." This presentation will illuminate the means by which recovery from a psychotic state can be facilitated through initiating connection with generational trauma, history, and heritage.

It is now widely recognized that trauma can be transmitted intergenerationally, often without conscious recognition by the subject, and that such long-buried trauma can be a key factor in the emergence of psychosis. The disconnection of an individual's micro, or "little," history from his or her ancestors' macro, or "big," history can also be a key factor in precipitating, intensifying and sustaining psychosis. (Davoine and Gaudilliere, 2004.) This is not salient only in regard to trauma. This presentation will demonstrate that the reconnection of an individual not only with buried trauma, but also with the broader traditions and historical record of ancestors, can facilitate recovery from psychotic states.

The process of recovery will be documented via engagement in intensive psychoanalytic psychotherapy with a young woman of Native American ancestry. Initially encountered in a psychotic and severely traumatized state, this individual was almost entirely cut off from, and ignorant of, her unique heritage. Through the course of treatment, it was the therapist-facilitated reclaiming of her history, culture and traditions of ancestors which catalyzed the patient's emergence from psychosis, and eventually enabled her to make meaning of her individual history.

Evidence from this clinical case will be utilized to address the more general importance of forging social links in the process of recovery from psychosis. Not only does the recovering subject need to make a deep and meaningful connection in the present moment with an engaged other; the subject also can be engaged in recovery by forging a link to his or her place in the larger history and heritage of preceding generations.

Elizabeth A. Johnson, PhD & Kathy Steinmetz, MS

Benign Visual Hallucinations during Empathic Attunement in Psychotherapy

What is and is not psychosis? As researchers, care providers and consumers have noted, the meanings of psychosis and even one of its often cited symptoms, hallucinations, can be widely varied and the experiences not part of an illness per se (Collerton, Dudley & Mosimann, 2012). Pixley (2012) suggested that work in psychodynamic psychotherapy with psychotic clients may involve an unconscious interplay between therapist and client that comes from the high levels of sensitivity involved in the interactions. The results for the therapist of such heightened sensitivity may be a blurring of reality that he or she is hesitant to share with other professionals, in spite of possible clinical insights gained.

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This presentation features a self-report by a practicing clinical psychologist, who experiences benign visual hallucinations, especially while working with frightened and psychotic clients. The case of one particular client who has a psychotic disorder and is chronically afraid is examined. It is suggested that the therapist's hallucinations may be an embodiment of empathy, and that this sensitivity in psychodynamic psychotherapy may offer a unique opportunity for enhancing the effectiveness of the therapy. A model of empathic attunement is proposed that considers a therapist's subjective experience of clients with a psychotic disorder or who are otherwise highly sensitive.

Nev Jones, MA

Unpacking Early Intervention in Psychosis

Over the past decade, early intervention in psychosis (EIP) has rapidly become one of the sexiest new areas of clinical specialization, service development, and intervention research (Edwards & McGorry, 2002; Bertole & McGorry, 2005; Birchwood et al., 2000). In this panel, the presenter will describe major themes from an ongoing mixed-methods user-led longitudinal study examining clients' and clinicians' perspectives on engagement, the therapeutic alliance, and the role of heterogeneous cultural/clinical explanatory models in the context of early psychosis. In keeping with the 2013 ISPS-US conference theme, the presentation will specifically explore varying attitudes toward diagnosis, psychiatric labels, and medication use, the relationship between these attitudes and engagement with different aspects of the EIP program, and impacts on clients' perception of their own agency with respect to their symptoms/experiences (cf Larsen, 2004, 2007a,b).

Bertram P. Karon, PhD, ABPP

Recovery of an "Incurable Schizophrenic"

A patient diagnosed as schizophrenic was evaluated by all his psychiatrists as "incurable" after several years of unsuccessful outpatient and two months of unsuccessful inpatient treatment, both with medications. Electroconvulsive therapy (ECT) was strongly but pessimistically recommended. He was not eating, not sleeping, and continuously hallucinating. He began outpatient psychoanalytic therapy. All medications were stopped. After three days, he began eating. After four months he began working at an intellectually demanding job. After two years, he could be assured that he would never be psychotic again under normal stresses. But that was not good enough for him. He kept raising new issues: problems in living, difficulties writing his first book, psychosomatic problems, problems enjoying ordinary pleasures, marital problems, undoing problems he had caused his son. The total treatment took 14 years. More than 20 years after the completion of treatment, the patient sent a note indicating his continued professional accomplishments and thanking the therapist for "giving me my life back."

Julie Kipp, PhD, LCSW

Evidence-Based Recovery: Overview and Report from the Field

Evidence-based practices are currently considered an integral part of recovery-oriented practice in the state of New York. This paper will provide an overview of the EBPs considered relevant for working with people with serious mental illness, and will address these questions: What practices are considered evidence-based? What is the evidence? What is the process for implementing EBPs, and what is going on in the field currently? What ethical issues need to be considered in determining which practices are evidenced-based, and in putting them into effect in the real world? What is the response of practitioners and consumers to these new practices?

The author will give examples from a recovery-oriented program in New York, overseen by the state Office of Mental Health. This type of program is still developing, as it has only been in operation for about 3 years in the New York City area.

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Gillian Stephens Langdon, MA, MT-BC, LCAT, Alison Cunningham-Goldberg, ATR-BC, LCAT, Kelly Long, MS, R-DMT, Kristina Muenzenmaier, MD, Lisa Oliveri, Ricky Perry.

A Bridge Between Trauma and Healing: Building relationships through verbal and creative arts therapies

"Recovery can take place only within the context of relationships; it cannot occur in isolation." (Herman, 1992)

People in an urban, long term psychiatric facility have been found to have high prevalence rates of traumatic events throughout their lifespan. Clinically, in addition to psychotic symptoms, we observe not just high co-morbidity rates of PTSD (Muenzenmaier, 2005), but also complex trauma-related symptoms such as alterations in the regulation of affect, attention, consciousness, self-perception, relationships, somatization and systems of meaning (Herman, 1992). As a result survivors of complex trauma often feel disempowered and disconnected.

The therapeutic relationship plants a seed towards the development of safe relationships and secure attachments. Music, art, dance and words can provide enlivening experiences of relationships beyond labels and constricted formulas. These connections include relationships to the self and others, to the art, to the body, to the music, and to the spoken and unspoken. Each modality can serve as a pathway to a therapeutic relationship, allowing trauma survivors to express themselves individually or in a group. The group environment allows for understanding and support of each other and the creation of a new culture of unspoken symbolic meanings.

In this experiential and didactic presentation, participants will actively explore the process of the creative arts and the role of words in inspiring and untangling expression. In addition, clinical vignettes will be discussed, focusing on the healing process.

Lois Oppenheim, PhD & Alice Lombardo Maher, MD

Film: How to Touch a Hot Stove: Thought and Behavioral Differences in a Society of Norms

This film, co-created by Lois Oppenheim, Ph.D. and Alice Maher, M.D., and directed by Sheryll Franko, addresses the problem of stigma associated with the words "mental illness", "wacko", "psycho", "nut job" and others. By presenting different theories about the nature, origin, and treatment of psychic disorders, the film compares and contrasts the destigmatization movement with other social movements like women's rights, civil rights and gay rights, and empathizes with the dilemmas of struggling individuals and the people who employ, teach, live with, financially support, and love them. Our vision of the stove in the title is both "top-down and bottom-up": The stove is touched by putting on oven mitts while the flame is also turned down. We illustrate in the film how other social / civil rights movements evolved in that way: Uprisings happened, laws were changed from the "top down," while individual people reached out to other individual people (blacks, gays, women) in ways that increased understanding and empathy and decreased inflammatory reactions over time. Simple ideas, like "Don't look away, but don't stare," and showing the audience the problem in a way that makes them realize that people with mental disorders – the obvious ones talking to themselves on the street and the high- functioning people who need to remain closeted – are among them, maybe even ARE them, were the impetus for this film.

Narsimha R. Pinninti, MD & Betty Mabine *Journey from being a Client to a Counselor in the Same Program*

This is the story of the co-presenter who joined a partial hospitalization program with symptoms of depression, psychosis and self mutilation. Symptoms were only partially responsive to treatment. Then she received cognitive behavior therapy interventions as a part of her medication management visits. She went on to have complete symptom remission and became a helper and role model for other clients. She also became good support for many of the clients and was able to encourage clients who were ambivalent to attend the program. Observing her uncanny ability to connect with other individuals, the primary presenter advocated for her to be employed by the organization. She was employed as a peer specialist in the same organization and worked in the same program. She worked for a period of three years as a peer specialist, and was a bridge between the clients and the staff. She was awarded the NJ association mental health agencies annual courage and compassion award and current is employed full time in a new position and has moved on from the organization. The authors will share details of the process of recovery, factors that facilitated her transition from client to a counselor in the same program, her own reactions to the transition and reactions of the staff and other clients. There will be some discussion also about confidentiality issues that may arise in such a situation.

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Peter Pretkel, PsyD, Adrienne DiFabio, PhD, Kristen Meyers, PsyD

Group Treatment for Psychosis in California Forensic Settings

California has a large forensic population with serious mental illness that includes individuals who are incompetent to stand trial, individuals who have successfully pled not guilty by reason of insanity, prisoners, and individuals on parole but deemed dangerous and not in remission. Until recently, psychological interventions to treat aspects of psychotic experience left unaddressed by medications were unavailable to this population. In 2010, psychologists working at California forensic facilities developed a group treatment manual for patients experiencing psychotic symptoms. The manual was primarily adapted from the current literature on Cognitive Therapy (CT) for psychosis, a well-researched and evidence-based treatment for a range of psychotic disorders. The manual emphasizes establishing a safe treatment environment, providing information about psychotic symptoms, medications, and coping strategies, and providing a forum for patient discussion of their subjective experience of voices, paranoia, and delusions. Interventions applied during use of this manual encompass the recovery model for the treatment of individuals housed in an inpatient forensic hospitals and inpatient forensic correctional settings. The manual is now in use in multiple settings. This presentation will briefly describe forensic treatment settings in California, outline the manual's content, and discuss patient, provider, and institutional response to the manual.

Richard Reichbart, PhD

The Anatomy of a Psychotic Experience: A Personal Account of Psychosis and Creativity

A relationship between psychosis and creativity will be explored via a personal presentation by a senior training and supervising analyst who will graphically describe his year-long psychotic experience over forty years ago, when he lived and worked on the Navajo and Hopi Reservations. He will discuss the development of a year-long psychotic experience when he lived and worked as a legal services attorney on the Navajo and Hopi Reservations, in Arizona and New Mexico, over forty years ago. He will show the dynamic and developmental roots of this experience, its creative as well as defensive function, how it made use of aspects of the Navajo culture and the haunting landscape of the Southwest, and finally, the denouement of the experience after a psychotic break and return to serious depressive neurosis. He will also discuss the intensive psychoanalysis that he underwent that permitted him to avoid an extended inpatient setting or reliance upon medication. Rarely do psychoanalysts speak of such personal psychotic experiences, which – if survived – add creatively to our understanding, in this case not only of a certain type of psychosis but of object relations in general.

In this respect, the difference between neurotic and psychotic reactions to object loss, including the effect of such reactions on memory formation and openness to sensual (including poetic) experience, will be explored. The exploration will involve detailed and graphic reconstruction of early childhood events as well as subsequent events that precipitated the psychotic reaction. The presenter also will argue that the term "psychosis" is often used so indiscriminately that it fails to differentiate between schizophrenia and other forms of psychosis, with the consequence that the type of psychotic reaction discussed here – amenable to intensive psychoanalytic intervention – does not appear sufficiently in our psychoanalytic literature.

Jeremy Ridenour, PsyD & Jason Moehringer, MPsy *Defense and Recovery from a Psychodynamic Perspective*

Is psychosis a defense or failure of defense? There have been two primary ways of conceptualizing the relationship between psychosis, defense and truth from a psychoanalytic perspective. From the first perspective, the individual's "repression" barrier between the conscious and unconscious parts of the mind is too permeable (Federn, 1943a-c). Primitive material arising from the unconscious overwhelms the ego and is discharged in psychotic symptoms. Hallucinations and delusions serve to externalize these unconscious contents outside of the individual's mind and allow them distance from their unconscious wishes and fears. From this perspective, a more supportive approach is needed that can provide the individual with the appropriate skills and healthy defenses to re-repress unconscious material that overwhelms the ego. From a second perspective, psychosis is a defense, an attempt by the individual to avoid some truth or trauma that is unbearable (Sullivan, 1927). Psychosis affords the individual the opportunity to avoid addressing a traumatic kernel, and psychotic symptoms allow the individual to escape into a private world in which they do not have to experience or communicate these experiences to the outside world (Bion, 1965). The appropriate intervention will require uncovering and exploring the unbearable reality that is being defending against so the individual can sacrifice the psychotic symptoms and integrate the trauma(s) that have necessitated the creation of psychotic symptoms. Research by Staring, van der Gaag and Mulder (2011) demonstrates that individuals who integrate their psychotic experiences rather than "seal over" have better chances for recov-

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ery. We will argue that both conceptualizations are valuable in promoting psychological integration and therefore helping the psychoanalytic clinician facilitate the individual's recovery. Additionally, through discussion of the origins of each perspective, we will establish guidelines and clinical indications that can assist clinicians in choosing effective intervention strategies when working with individuals who experience psychosis.

Paul S. Saks, PhD & Guy Ravitz, PhD

"An Absence of Darkness in Infinite Degrees": Recovery Through Psychodynamic Therapy in a State Psychiatric Center

The title of this paper is derived from a quote by Leornardo DaVinci, "A shadow may be infinitely dark, and also an absence of darkness in infinite degrees. The beginnings and ends of shadow lie between the light and darkness and may be infinitely diminished and infinitely increased." State Psychiatric Centers are often perceived as places of darkness where overmedicated patients, their agency obliterated by a rigid system, are left to decay in bleak and sterile halls. The authors of this paper, while acknowledging that these hospitals can indeed be dark places, contend that they are more akin to Da Vinci's shadow. With an intensive program of psychodynamic psychotherapy (both group and individual), sensitive pharmacology and effective case management, there is indeed the possibility of recovery, thus allowing for remarkable individuals to emerge between the beginning and end of light and darkness. The presenters of this paper will present the case studies two such individuals, a young woman with a severe trauma history whose treatment extended past her successful discharge, and a man who believes he is a dragon. The presenters will speak for the efficacy of using psychodynamic psychotherapy with psychosis as a viable modality of treatment, even when faced with an environment rife with systemic issues.

Burton Norman Seitler, PhD, Lloyd Ross, PhD, Robert J. Sliclen, PhD

What's in a Name? What's in a Diagnosis: Deconstructing the DSMs

Allen Frances, and before him, Robert Spitzer, both well respected Editors of, and contributors to earlier versions of the DSM, have come out against the latest American Psychiatric Association's (APA) manualized incarnation, the DSM V. However, as strong as their arguments are, they are not nearly sufficiently potent or come soon enough to avert the harm that they predict will ensue, or to undo the harm that has already occurred after the APA introduced the ADHD, childhood bipolar disorder, and other diagnoses. Now grief and shyness are going to be pathologized, along with other responses to the rigors of everyday living.

If the makers of the previous DSM versions had gotten it right the first time, why is there still the need for so many emendations? This fact alone illustrates the inaccuracy of diagnoses. This panel will show that applying medical diagnoses to emotional experiences contains serious inaccuracies, including lack of scientific validity and reliability.

We will present evidence of significant flaws in the rationale, reasoning, and research behind the DSMs and the consequent harm that they have created. Diagnoses simply serve countertransferential wishes for certainty in order to assuage therapists' anxiety regarding not knowing, ambiguity, and experiencing our own terror inherent in the conflicts that our patients induce in us. Alternative conceptualizations and practices will be considered. Finally, we will make a plea for redirecting our focus back to trying to understand and treat patients as unique human beings, as individuals, rather than labels.

Steven M. Silverstein, PhD

Update on risk and resilience factors, and the nature and effectiveness of efforts to prevent schizophrenia

Recent years have seen advances in our understanding of risk factors for schizophrenia, and the development of clinics for young people at risk for the syndrome. At the end of 2013, what have we learned from such efforts, and how close are we to being able to prevent schizophrenia from occurring? This presentation will address these issues by: 1) reviewing the latest data on risk and resilience factors related to schizophrenia; 2) describing approaches to identifying people at high risk for schizophrenia; 3) discussing methodological, societal and political issues involved in making changes that might reduce the risk of schizophrenia; and 4) describing data on the effectiveness of high-risk clinics, as well as suggestions to obtain better outcomes. Among other conclusions, it will be suggested that: 1) intervention must begin at an earlier age than is current practice, and this can be done in a non-stigmatizing manner; and 2) we may be able to improve our understanding of risk and resilience factors by examining other conditions where the prevalence of schizophrenia is far below that in the general population.

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Ross Tappen, MA & Gladys S. Valdez-Blake, PhD

Group Work Essentials – An Interactive Workshop

While group treatment is omnipresent in inpatient and outpatient mental health settings, training in group work lags far behind. Many groups are topic based and clients are assigned to them based on their symptoms, life history or demographics. The panelists will present a workshop on conducting a process-oriented group psychotherapy treatment used in a long term state hospital inpatient setting. In this process group model, clients are chosen based on their interest in setting goals for themselves, their capacity to speak openly with the interviewer and their willingness to participate in the training model.

The training model attempts to provide a safe setting for psychiatric inpatients that creates optimal conditions for therapeutic change. At the same time, the model seeks also to provide an intimate, hands on training experience for predoctoral psychology interns. The group begins with the trainers conducting the group and interns silently observing in an "outer circle" which is set up around the perimeter of the therapy circle. The trainee observers begin to rotate into the group as conductors. After each session the interns and senior staff meet to examine the process of the preceding hour. These kaleidoscopic roles shift over the course of hours and weeks throughout the training year and provide parallel vantage points for senior staff, interns and clients. Thus, each group member is being observed and treated, but also observes and teaches. Each intern observes and supervises from the outer circle, but is also observed and provides treatment from the inner circle. The supervisors are demonstrating to the interns, observing the patients and the interns, and supervising and being supervised by the interns.

The first part of the workshop will consist of an overview of the treatment / training model, including the particular elements necessary to create a safe therapeutic environment, including time, place, protocol and consent; a statement of the training goals of the model and presentation including an understanding of the feasibility of doing process oriented work with psychiatric inpatients; ability of the trainees to identify and work with essential elements of group process such they are able to replicate. In the second part of the workshop there will be an in-vivo demonstration of the model with panelists and workshop members engaged in group process, with other workshop members observing, followed by a discussion and processing the group experience.

Ross Tappen, MA, Rodney Waldron, Sara E. Zoeterman, MA

State Property, or Your Property? A support group for voice hearers in a public hospital setting

There is broad support for the idea of engaging people with psychotic and unusual experiences in a way that seeks to understand, accept, appreciate those experiences as a means to recovery. A partial sampling of authors from diverse perspectives and disciplines that in some way endorse this approach would include Romme and Escher (psychiatry), Karon (dynamic psychology), Turkington, Kingdon and colleagues (CBT), Peggy Swarbrick (Occupational Therapy), Bach and Hayes (Acceptance and Commitment Therapy) and Rufus May and Ron Coleman (Experiential, Peer-based).

However the idea that in psychosis distinctively, what the patient is experiencing should be downplayed, eliminated or suppressed, in the mind of the clinician as well as the client, remains ascendant and has influential representatives (Lieberman, President of American Psychiatric Association). The acceptance or rejection of meaning in the experience of people with psychotic experience constitutes a fundamental divide from which flow very different construals of recovery, as well as different ways and means to address the challenges of recovery.

The panelists will present a group, called "Voices and Visions", piloted in Fall 2012. The group is an example, in a structured institutional environment – a state psychiatric facility – in which people come together to exchange views, share inner and outer experience, in a nonjudgmental and noncoercive setting that allows for individual ownership of experience. It is a community based model that is taking place within a psychiatric institution. The panelists – peer specialist, psychology intern, and psychologist – will discuss their experiences in establishing the group with guidelines that diverge from the institutional norm. They will also discuss the process-oriented, clinical aspects of conducting the group and how they bring their individual perspectives to the session, as well as how the members' own use of the group has shaped the approach over time.

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Ron Unger, LCSW

Understanding Psychosis as an Attempt at Transformation: Integrating Perspectives on Trauma, Spirituality and Creativity

While psychosis is commonly understood as something going wrong within a person, and while many treatment approaches attempt simply to stop that process, this workshop focuses on an alternative view that sees psychosis as resulting from attempts to resolve problems that preceded the psychosis. In this view, psychosis may be initiated by a dangerous type of experimentation or creative process, where people (especially young people) consciously or unconsciously try out new ways of seeing, believing and behaving to address life and spiritual dilemmas caused by their stressful or traumatic experiences. These are dilemmas which they were not able to master using tools provided by their family and their cultural background. Psychosis can deepen when this process of experimentation leads to errors in beliefs, perceptions and behavior, resulting in more trauma and distress, and then typically more misguided responses by self and others, in an increasingly severe vicious circle. There remains however the possibility that with assistance by people who understand this process, and with continued experimentation rather than suppression of experimentation, both the original difficulties and the difficulties resulting from attempted solutions that backfired can be resolved in ways that lead to personal and possibly even cultural renewal and health.

Elizabeth Visceglia, MD

Healing Mind and Body: Using Therapeutic Yoga to Treat Symptoms of Schizophrenia

As the author of the first study performed and published in the US on using yoga in the treatment of schizophrenia, I have always been deeply interested in integrative approaches to mental health. I performed this study at Bronx State Psychiatric center with no funding, and although the study was small, we had remarkable results. I will conduct a session that is both experiential and theoretical. I will give an overview of the research on yoga and schizophrenia, psychological theories about why yoga is so effective, and biologic/physiologic explanations of likely mechanisms of action of yoga practices. In addition, there will be important experiential aspects, including teaching participants basic but extremely healing breathing and movement practices – practices that can be safely used by anyone for one's own benefit or taught to someone suffering with the symptoms of schizophrenia. I will also give case histories of people I have worked with over the years and share the way that practicing yoga has improved their lives, whether as outpatients or during long-term hospitalization. Through this workshop, we will all develop a deeper understanding of the ways that yoga can be a highly effective adjunctive healing modality for those suffering with schizophrenia, and the remarkable effects – biologically, psychologically, and socially – that yoga can have when properly utilized.

Sharon Young, PhD & Matt Snyder, MA, LPC

Recovery Realized: A Conceptual and Outcomes Summary from a Progressive Therapeutic Community Environment

CooperRiis Healing Community in Western North Carolina has made it a priority to collect outcomes data from its diverse resident population since its inception in 2003. This ISPS session will provide an overview of this unique healing environment which represents a conceptual hybrid of the traditional therapeutic community model and the progressive recovery model. Ten years worth of quantitative, qualitative and behavioral data will be summarized with a particular emphasis on the subgroup of individuals that have experienced symptoms of psychosis. Along with reviewing the various types of data independently, the presenters will also point out the most salient findings that are supported by the convergence of different types of data.

The Eye with Which We Behold Ourselves
Poetry Therapy in a State Psychiatric Center

Paul S. Saks, Ph.D.

The title of this article is derived from the "Hymn to Apollo", in which Shelly celebrated the ancient connection between poetry and healing. Phoebus Apollo the Sun God was deity of both poetry and healing; his son Asclepius was the mythic forbear of all physicians. Spells, incantations, invocations and chants, poetic forms all, have from the dawn of time been the therapeutic tools of priests, shamans and witchdoctors. Ancient Egyptian physicians, as far back as 4th millennium BC wrote verses on pieces of parchment, and dissolved them in potions so that the words could have the quickest affect possible. In the Bible, David used his Psalms to soothe the savage beast that was King Saul. The Roman doctor Soranus prescribed tragedy for manic patients and comedy for depressed ones. Modern psychology has been rediscovering what many have known intuitively through the ages, that poetry in both its creation and reading is an effective healing device that reaches out to us on many levels. As Freud said, "Not I, but the poet discovered the unconscious".

The power of poetry is that it gives voice to those things that, for a variety of reasons might normally go unsaid. In psychotherapy, which traditionally runs in a "talking cure" paradigm, the screen provided by poetry can allow for the expression of traumatic and affect laden material in a form that is less threatening than direct verbalizaton, allowing for it to be processed and integrated into the self. It can also provide a sense of structure that can then be translated into greater cognitive organization. When presented in a group format, the reading and creation of poems is a way to create group cohesion and encourage participation from even the most withdrawn and isolated of members. This type of group can be a powerful experience for anyone, but can be particular effective with those labeled at the severely and persistently mentally ill.

The writer of this piece has been running an inpatient poetry therapy group at Manhattan Psychiatric Center for approximately one year. Though there has been some movement in relation to discharges and admissions, membership generally includes 8-10 patients, all of which carry diagnoses of psychotic disorders; of the current group membership, two are original members. The group is usually led by the writer of this piece and an intern co-leader. Before joining the group, potential members are screened for level of literacy, interest in poetry and level of cognitive functioning; though the group tries to be inclusive an ability, material runs from Shakespeare to Maya Angelou, so an ability to read and process the poetry is essential. The frame of the group is essentially the same from week to week. After an initial check-in, members share poems they have written on their own during the week; these usually relate to the theme discussed in the previous group. Poems written by group members never fail to humble this writer; regardless of their technical virtues (and some can be impressive), they inevitably are highly personal, elegant expressions of thoughts and feelings. They are always met with the rapt attention and warm support of the group members.

The phase of the group involves the leaders presenting several poems on a theme, or what Jack Leedy (1985) referred to as the "isoprincipal", selecting poems that the facilitator feels matches the mood of the group or encompasses an issue shared by many of its members. The themes can center around a particular poet (the group has tackled the works of Plath, Milton, Poe, and others), a style (Haiku, for example) or can be seasonal or related to stories in the news. It is crucial that the poems be read as a group, with each member reading several lines aloud; as stated above, this usually has the powerful effect of drawing in all of the members and creating a unity of purpose. Even those members who are considered to be "internally preoccupied" are able to follow along and read at the appropriate time. When the reading is concluded, a discussion ensues. Themes such as depression, abandonment, isolation, stigmatization of mental illness, family issues and mourning have arisen in the past. Again, members who are routinely labeled as "non-verbal" regularly express their feelings with sophistication and elegance; the writer believes that through the vehicle of analyzing poetry, difficult topics are broached and permission for open self expression granted. If time allows, the group will then begin the writing of poetry in the group.

Perhaps the best way to conclude this article is in the voice of the remarkable and men and women who participate in the group. The following extraordinary poems were written in the poetry group, and used by permission of the authors:

At Harry's Five and Ten
The little plastic baby doll costs a nickel
The red rubber ball was had for a dime
The balsa wood airplane's price was more than any allowance could claim
But dad thought it finer than the blue box kite.

Tobacco
Mother to be expecting a child
Birth begins at conception.
Smoking out the infant,
Escaping the ammonia, poison gas chamber effects.

Poems by Derick Jay Adams

At age fourteen, while living in Long Island, I wrote my first poem, a crude poem called city birds and a yearning for freedom, believing that these birds had more freedom than I did. I've come a long way now from yearning to be a pigeon. Adulthood has brought freedom but with the price of responsibility. My poetry along the years has developed from elementary poems to practicing couplets then trying to master sonnets and free verse. Now I have my own unique style of writing. My trials and tribulations in life are reflected in the two books of poetry I have written : Emotions torn Asunder and Emotions Sewn Together. These books contain the reality of life through my eyes and the emotional roller coaster that has gone along with it.

They often say that there would be no joy without pain. There also would be no elevation without a bottom. And one must persevere through the hard times to reap the rewards of the good times. I found that doing what you love to do in life and completing small tasks day by day will be your legacy. I wasted much of my life in immaturity and impulsivity and spent many years incarcerated and institutionalized. What I've learned from these wasted years was to heed the advice of others and that I did not know it all. Education became my prime concern in my life and teaching a younger generation that life is too short to waste. I feel fortunate to have prevailed through difficult years and to have been able to share my thoughts and feelings in my published works. Here is a sample of these:

TRIPPING

I'm just naturally tripping

Sipping on coffee mind steadily gripping

Not slipping on things that feeble minds
Stay flipping on

Ripping an entire new path of realistic
Thought

I fought for many years and sought many
Books of wisdom bought

Many philosophies I caught onto what
Life is and taught what I learned

Short of nothing but miracles you ought
To ride with me

Just start by looking within

Yeah that's where you begin

I'm just naturally tripping

TO BE ALIVE

To be alive is not just breathing

Heart just pumping
Mind just thinking

No

To be alive is more

To be alive is to be free in spirit

Free in caring

In touch with your emotions

To be alive

Is to be free of hatred

To be alive

Is to be loved and to love

To be alive is to wake anticipating
Another day

And to have dreams not just at night but
For the outcome of your life

(NOTE: Emotions Torn Asunder and Emotions Sewn Together are available from the author. Derick50@ymail,com)

Poetry from I AM NOT AFRAID

These poems are from the book of poetry I AM NOT AFRAID by Mary Lou Tornes. She writes about love and loss and mental illness. The book is available through Amazon.com.

Bellevue

I know the yellow – stained carpets
Of Bellevue's halls
TV room, three hallways, dining room,
Back and forth.
The worst of it was when
They would take away my clothes
Huge yellow gown, bare feet
Some strange kind of desolation
Not like the "nada" of St. John of the Cross
Though that was what I believed,
Wanted to believe.
I was splintered, humiliated, lost.
I was mad.
I wandered the halls
Never for a moment without the voices.
There are no words for the suffering
Of this time in my life.

Anniversary

You are gone now from this earth.
It has been four months.
Your death has become a part of me.
I wake up and fall asleep with it.
The picture of us in Vermont
Taken eight years ago
Hangs in my kitchen.
We are smiling.
It is a bright summer day.
We are wearing our jeans
And Timberland boots.
Somehow I thought you would win the battle
Against suicide.
Eleven years of constantly going
Into mental hospitals
Wore you down.
You said to me,
"I have lived my life in hospitals."
I understand, Roz.
I love you still.

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